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Surgery.

PROSTATIC HYPERTROPHY.

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Prominent among the many ills that, until recently, were relegated to helplessness and hopelessness was the hypertrophied prostate and its associated genito-urinary lesions. And although in the last few years specialistic research and clinical experience have done much to increase our knowledge in this direction, I have no hesitation in saying that from our medical rank and file the subject is still far from receiving the attention it merits.

Causes: They are not understood. It is surmised by some that prostatic hypertrophy is one of the foot-prints of Bacchus or Venus, or of both. This, however, is merely conjectural, and it is not surprising that the etiology should be unknown, when, among some, even the physiology of the gland is a mooted question, some believing it to be an accessory organ of micturition and others that it is a sexual organ. It might be one or both inasmuch as it is perforated by the urethra and common seminal ducts.

That its essential function is sexual would seem to be borne out by the fact that it is found to atrophy, in both man and animals, after castration, and that among some animals it is much enlarged during the breeding season.

There has been an attempt made to associate prostatic hypertrophy with the general atheroma of advancing years. So far, however, the relationship has not been established beyond the fact that they occur co-incidentally. Nor with the gouty diathesis save that they are more prone to lesions of the genito-urinary tract.

The prostate is regarded by many as the analogue of the uterus, and that the hypertrophy is of the fibroid or myomatous nature, like that which occurs so frequently in the uterus. There is some ground for this belief. In the latter half of the reproductive period, both prostate and uterus are subject to hypertrophic changes, the histology of which is quite similar—fibro-myomatous. But these facts throw no light upon the etiology.

This hypertrophy is thought by some to be a remedial lesion—that as age comes on the base of the bladder sinks and the prostate enlarges, to keep the base of the bladder on a level with the urethral orifice. And, therefore, the residual urine precedes the hpertrophy. This theory has few supporters.

As pathological data we know that the gland may undergo general hypertrophy and maintain its normal shape; but most frequently it is irregular. The hypertrophy sometimes consists of growths apparently identical with the uterine fibro-myomata—round, firm growths, easily shelled out, often multiple and formed of concentric fibrous layers.

Such growths may form irregular projections from any portion of the gland into the bladder. The gland may vary in size from that of a horse-chestnut to an adult fist. In the latter case the prostatic urethra is lengthened and usually made irregular. The gland may grow mainly in the direction of the rectum, or one lateral lobe may be the main seat of hypertrophy, or the "middle lobe" may grow upward and overhang the urethral orifice like a valve. Again, by its more general enlargement upward, the orifice of the urethra is raised above the *basfond*—establishing ante- and post-prostatic pouches. Occasionally, the urethra may be kept patulous by irregular projections into it, and enuresis, partial or complete, is the result; oftener, however, obstruction to the outflow results.

It is not known how long such a lesion exists before the patient begins to suffer, but sooner or later the mechanical obstruction to complete evacuation of the bladder contents, disturbed circulation, nerve perturbations from pressure, residual urine and septic infection produce most dire manifestations.

The obstruction and more or less retention, causes dilatation and consequent atony with degeneration of the bladder walls; or, in cases where vigorous and frequent bladder contractions occur there is much thickening of the vesical walls and consequent diminished bladder capacity. Here trabeculæ are hypertrophied, and feel like ridges or cords to the palpating finger. The pressure thus exerted upon the slowly escaping fluid causes sacculations in the weaker portions of the bladder. The ureters and renal pelves are dilated, the interstitial connective tissue is increased while the renal substance is decreased. With impaired circulation in the vesical mucous membrane it can offer but little resistance to infection from fetid or ammoniacal urine. This is often hastened or aided by the introduction of dirty catheters. Or, if they are sterilized, filth may be carried in from a foul meatus and cystitis is the result.

Intense inflammation, then, is a frequent accompaniment, and with the inflamed and suppurating mucous membrane the urine becomes intensely irritating, and the mucous and pus collect in the post-prostatic pouch and the viscus is constantly irritated by urine which it cannot expel. Catarrhal pyelitis and interstitial nephritis are not uncommon from

the infection traveling upward through the dilated ureters. From over-distention, sacculation, crippling of the detrusor muscles, or degeneration of the bladder walls, loss of evacuative power results.

Symptoms: Their onset is variable as to time and character. As to time, they manifest themselves most frequently about the age of fifty, although it is evident that the hypertrophy exists long before the symptoms appear. In fact, Harrison has demonstrated that not infrequently cases of prostatic hypertrophy exist that never give rise to any vesical or constitutional symptoms. Frequent micturition is one of the earliest and most intractable symptoms. It is worse at night, worse from long walks, rough carriage rides and when rising from a sitting or recumbent position. In two of my patients this symptom appeared during a protracted railroad journey, and in this way called attention to the enlarged prostate. The urinary efforts increase in frequency till the patient has little or no peace. This symptom is generally attributed to residual urine, which the bladder is incapable of voiding. I do not believe this, however; at least during the early stages, while the urine is normal. For, at this period, if the bladder could expel all but a few drachms this could not cause any more irritation than a similar quantity reaccumulating after complete evacuation. (White). Of course this will not apply later, when there is cystitis and fetid urine. Moreover, I have noted this symptom in cases where it was impossible to demonstrate the presence of any residual urine. I am, therefore, led to believe that the agonizing frequent micturition is due to irritation of sensitive nerve fibrils of the sympathetic system.

Now, I have the profoundest respect for the great sypathetic system; at the same time there are conditions in which it shows that it possesses sensation, but no common sense. For instance, if there is an abdominal lesion that requires perfect visceral quiescence the sympathetic system insists upon emesis; if there is a pharyngitis constant deglutition is a concomitant; if there be a stone in the bladder there is pesistent vesical effort. And so I believe in regard to the frequent urination accompanying the enlarged prostate. I believe it is reflex, and its constancy, frequency and intractability show the truth of Emerson's statement: "When nature desires us to do a thing, she overloads the tendency."

Of course we can understand the frequent micturition at a later period, when urethro-cystitis and fetid and ammoniacal urine exist.

Difficulty in starting the stream is another early symptom. It may be caused by obstruction, spasm of the external sphincter, or relaxing of the detrusor muscles. Or the valve-like projection, before alluded to, overhanging the urethral orifice could likewise produce this symptom. The "stammering bladder" may result from the action of this projection which is drawn down upon the urethral orifice by the outflowing stream, and then rises to its former position as soon as it has stopped. Or, the same starting and stopping of the stream results from the alternate tiring of the detrusor muscles and the contraction of the sphincter vesicæ.

Incontinence is another early symptom in some patients. Nor can I agree with what is usually written as to the cause of this. Some writers say that it is always a sign of atony and a full bladder. I am well aware that such is usually the condition of the bladder when the patient is suffering from *enuresis passiva*, which represents the overflow, but I have demonstrated that this symptom may exist without atony and a full bladder. Coulson, Moullin and others believe it is due to irregular projections from the prostrate, which keep the urethra more or less patulous—or at least, prevents its proper contraction. White does not believe that such a condition ever obtains. Coulson says it does, but incautiously adds that it is "usually irremediable." I am satisfied that the latter writer is correct as to his pathology, but mistaken as to its amenability to treatment.

That irregularities in the prostatic urethra can result in *enuresis activa* is not at all strange. As analogy, we all know how frequently patients speak of the temporary inconvenience, arising from the involuntary escape of gas from the bowel after resection of the pile inch. It is due to the fact that the newly placed mucous membrane has not yet become accustomed to being properly infolded within the sphincteric grasp. It does not maintain the bowel in a patulous condition, but the mucous folds have not been fitted so as to permit of perfect co-aptation. So much for analogy; case first illustrates the condition as a clinical fact.

Additional engorgement of the already inflamed prostatic urethra and complete atony, are the conditions generally held responsible for retention. If from the former, it is a most unfortunate occurrence, as it tends to destroy whatever tone the bladder walls may still possess. It is probable that the size of the gland, the thickened bladder walls and the consequent loss of elasticity and contractility explain some cases of retention. The sclerosed walls cannot properly collapse, and residual urine is the result; and as this increases so does the frequency of urination, because the constant residuum practically diminishes the capacity of the bladder.

Slight hemorrhage is not infrequent, but is of no special significance.

The urine may remain normal for months or years, in spite of the residuum, but more frequently oxaluria, albuminuria, or polyuria will be found. When, from infection, which usually occurs later, a cystitis is established, the residual urine becomes ammoniacal, fetid and loaded with pus, blood and mucous.

Hemorrhoids protrude, from the constant straining. Sexual erethism will be noted in some patients; in others impotence. Dull heavy ache in the perineum, a feeling as if the rectum were loaded, and pains down the thighs and calves of the legs, or even to the sole of the foot, are characteristic.

Constitutional symptoms depend largely upon the complications—except in rather advanced cases when the frequent urination alone is enough to wear the patient out even if unaccompanied by pyelo-nephritis and uremia. The vesical irritability is agonizing; tenesmus drives the patient to the urinal and the completion of the act is soon followed by the urging pain and burning. This ceaseless tenesmus, and the attempt to relieve it, makes rest impossible. The appetite fails, the patient begins to emaciate and the breakdown becomes imminent. If to this is added the renal complications the pupils are contracted and unequal in size, the tongue becomes dry and furred and the patient may sink rapidly from uremia or septicemia or both. Old prostatiques suffer in mind as well as in body. Many of them, especially the gouty, are irritable and haunted with forebodings. They are melancholy and hypochondriacal and dread to have night come.

Diagnosis is easy and may be made to a certainty with one finger in the bowel and a sound in the bladder; nor is the latter always necessary. We

feel quite certain about the prostatic enlargement, if the above group of symptoms present themselves in a patient about fifty, and it cannot be excluded, even if the patient is younger. The writer has one well marked case, aged thirty-eight years. Of course, we should be careful to exclude stricture, vesical and renal calculus, vesical carcinoma (or other growths) and vesical or renal tuberculosis.

In examining the urethra, I think it wise to begin with a silk, or linen, olive pointed bougie (size from seventeen to twenty in the French). Or, I use the cylindrical bougie, which reveals more clearly the existence of projections or irregularities. When the urethra is quite tolerant the bougie *a boule* is preferred. These latter instruments will occasionally give a distinct feel of two or more projections into the urethra, which may be deflected in any direction so that only a Mercier catheter will find its way through. I saw one case in which prostatic dilators were introduced and separated three-quarters of an inch and still the flow was obstructed. This argues in favor of the upward enlargement and valve-like action of the middle lobe. If the stream which escapes through the catheter is feeble and without its physiological curve we know that the bladder walls are already atonic. In well marked cases it will also be noticed that the urethra is lengthened. The gland is usually not very sensitive to the palpating finger, and this serves to distinguish it from the acute prostatitis. We should remember that metallic instrumentation, especially the first time, may produce a decided aggravation of the symptoms and that it is better to confine ourselves to the use of non-metallic bougies; at least until we have demonstrated that the urethra possesses some degree of tolerance. I have already stated that residual urine is not a necessary accompaniment of an enlarged prostate, although it is well to examine for it. And here I wish to call attention to an error that is prevalent relative to this condition. Many have the impression that residual urine can always be drawn off through a catheter. If due to atony it can, as a rule (although there are two cases of atony reported where catheterism was powerless to provoke an outflow of urine), but if the urine is lying in a pouch lower than the urethral orifice, the mere introduction of a catheter cannot draw it off. The orifice is surrounded by a dam, as it were, and the eye of the catheter has to rise to the level of this dam before it is really in the bladder. There is a lesion in the logic of the teacher who talks of invariably drawing off the residual urine with a catheter.

The *diagnosis* is far more important than difficult. Many of these cases drag along under such diagnoses as "kidney trouble," "gravel," "bladder trouble," etc., and die years before it were necessary, had the real lesion been recognized, and the importance of such recognition lies in the fact that only through this can the patient's last days or years be made comfortable. I have seen a physician, in consultation, draw his fingers over the external surface of the perineum and this was his conclusion: "This prostate is not materially enlarged, because I cannot feel it bulge through the perineum." Now mark the utter puerility of such a statement. A perineal section was performed and the patient was so stout *and the perineum so deep that the finger was not long enough to palpate the bladder through the incision*, and a high cystotomy was necessary. Think of trying to palpate a prostate gland through a perineum of such a thickness as that! But such blunders will be made just as long as there are practitioners who will not attend medical society meetings, or read live medical journals.

I make this plea for diagnosis because the earlier it is made the more promising the treatment, either operative or otherwise.

Treatment: With the onset of the symptoms, local treatment should be instituted. The symptoms may have existed only a few weeks and yet upon examination the gland may be found very much hypertrophied; showing that the affection had begun long before it manifested itself by means of the urinary disturbance. The routine treatment in the incipient stage, or even later, can easily be conductod by the general practitioner, and to illustrate it I select three cases from my records, which will represent the different stages in the progress of the affection, and the treatment varied according to the existing conditions.

Case I.—Mr. D——, aged thirty-eight. Had been "on the road" for a number of years and was a devout worshiper at the shrine of Bacchus and Venus. Four weeks before presenting himself he began to notice an increased frequency in urination, especially at night. This was soon accompanied by enuresis—slight dribling when changing posture. The tenesmus, pain and burning became gradually worse until he was compelled to seek advice. Rectal examination revealed an enlarged prostate. A flexible cylindrical bougie (No. 17 French) was passed and gave a distinct feel of passing over three irregular projections. It then entered the bladder with the characteristic prostatic jump. It was allowed to remain five minutes, and was then followed by the introduction of olive pointed bougie, of the same material, numbers 18, 19 and 20. Each was allowed to remain from three to five minutes. His urine was normal. He was given *Saw palmetto*, first decimal dilution, five drops *ter in die*. In two days he returned and reported, with much surprise, that the treatment had pomptly checked the enuresis, that the stream was more natural and the dysuria much improved. To be brief, he was subjected to instrumentation three times a week for the first fortnight, then twice a week, after that only once a week, and then instructed to pass a No. 20 bougie *a ventre* himself, every three days and let it remain for five or eight minutes. This was to be discontinued after a month, and resorted to again if there should be any recurrence of the urinary disturbance.

The symptoms subsided kindly. When dismissed he could hold his urine for three or four hours during the day, but was obliged to get up once, and occasionally twice, every night to empty the bladder. After indulging in long walks he was threatened with a recurrence of the prostatic irritability. Of course this patient still has the enlarged prostate, and probably always will have, and eventually he may demand operative treatment; but for the present and perhaps for months or even years the lesion may be held *in statu quo* by the above treatment.

This should be carried out with the strictest asepsis. In this class of cases bougies are preferable to catheters because the use of the latter soon accustoms the bladder to emptying itself without any expulsive effort and vesical atony is the result, and then catheterism becomes a necessity. This citation proves that we need not wait for the age of fifty for prostatic hypertrophy, that frequent micturition is not always due to residual urine, that the *essential difficulty is not always obstructive*, that enuresis is not always an indication of atony and a full bladder, that prostato-urethral irregularities can be responsi-

ble for incontinence and that it is not irremediable. Here, then, are a number of peculiarities in one patient that are contradictory to what has been quite extensively taught. Harrison says we should "approach this subject in relation to obstruction rather than in reference to its mere increase in size." I say we had better approach it, at least in its early stage, not alone in relation to its obstruction but to *its reflexes as well*, and as evidence of this we have only to refer again to case first. The treatment was not for the relief of obstruction but to obtund the sensibilities and, as it were, "smooth the bore" of an irregular and irritable prostate.

Case II.—Mr. S——, aged fifty-five. (Is cited to illustrate the condition more advanced). A traveling salesman. For over a year he had been suffering from frequent micturition, pain and burning in the penile end, dull aching in the perineum, pains down the inner sides of the thighs, etc. His sleep was much disturbed at night, the tenesmus vesicæ compelling him to leave his bed a dozen times or more in a night and was so troublesome during the day that he was obliged to give up his business. His face was thin and careworn, and had a haunted look, the pupils were contracted and unequal in size, tongue somewhat furred. He had taken much medicine with little or no relief. The urine was foul and loaded with mucous, pus and phosphates. The index finger in the bowel easily made out the prostatic enlargement. A number 14 cylindrical bougie was passed without much difficulty, meeting but a slight obstruction at the urethro-vesical junction. Then a Mercier catheter was introduced, with greater ease, and some residual urine drawn off and the bladder washed with warm *Boric acid* solution. Some of this was left to take the place of the residuum in the bladder, and bougies up to No. 17 in size were passed. He was given *Benzoic acid*, third decimal. His bladder was washed out twice daily and his diet restricted. He drank lithia water faithfully. For ten days this treatment was continued with practically no relief. In the meantime *Berberis* had been exhibited, also *Cannabis sat.* The urine was still foul and irritating. *Peroxide of hydrogen* was substituted for the *Boric acid* solution, but with no better results. Then *Thiersch's* solution was resorted to with the most prompt and gratifying results. The urine began to clear up, the dysuria diminished, his digestion improved, and rest at night became again possible, and he was soon able to resume his business. He is now obliged to get up only two or three times during the night, and can hold his urine comfortably for three hours during the day. While he can, for the present, attend to his business with a considerable degree of comfort, I regard him as the possessor of a very much damaged urinary apparatus, and believe that sooner or later he will be a candidate for cystotomy. As in this case, it must not be expected that under any course of treatment the patient is to recover his full bladder capacity.

The degree to which the bladder walls may be degenerated is shown by White's case, in which the staff escaped from the bladder through its anterior wall. I had the pleasure of holding the guide for my friend Van Lennep three years ago when the same condition was found and the instrument tore through the bladder wall with the same ease.

It is unreasonable to expect that long continued inflammation, suppuration and ulceration, followed by healing and cicatrization, can leave bladder walls in possession of their normal expansibility and contractility.

As general measures, with these non-operative patients, they should wear flannels, unless in warm climate, and avoid exposure to cold, long walks and rough rides. Diet and sexual habits should be regulated and restricted. Alcohol should be interdicted and care should be exercised as to the drinking of large quantities of fluids. A sudden excess in the amount of water drunk may invite a recurrence of prostatic irritation. There should be regular times for emptying the bladder, especially if the catheter has to be used. Not only should distention be avoided, but the occasions and conditions that might lead to retention where its relief would be difficult or delayed. I insist upon such patients receiving instructions in the use of the catheter, with which they are provided, when about to undertake a railroad journey. As before stated, bougies should be used whenever practicable, instead of catheters, and thus retain the power of vesical propulsion as long as possible. If there is foul residual urine it is necessary to employ a catheter for purposes of intra-vesical irrigation. For evacuative purposes it should be used as infrequently as consistent with the avoidance of distention. If used only once a day it should be just before bed-time.

Such treatment as outlined above, aided by such remedies as *Mercurius corr., Pulsatilla, Aloes, Lithium carb., Terebinthina, Cantharis,* and those previously mentioned, will do much toward keeping these unfortunate patients comfortable, and even if it does not always obviate operation it postpones it. It is a matter of regret, however, that they are often so far advanced that neither dilatation, catheterism, nor irrigation will afford relief, and operation becomes imperative.

Case III will illustrate.—Mr. D., aged seventy-nine, chief of division in department United States Treasury. Had been complaining of urinary disturbance for three years. His physician, Dr. F. A. Gardner, who kindly referred the patient to me, had tried the most approved palliative measures without materially checking the progress of the affection. The patient had a horror of approaching night with its attending misery. His nights were spent in helpless, hopeless and ceaseless efforts at micturition. And, even during the day, he would turn from the physician abruptly, urged on by resistless urinary efforts. His face was careworn and anxious and had the haunted look before spoken of. He had a well marked aortic insufficiency. Digital examination revealed an enormously hypertrophied prostate, widening out and rising above the reach of the examining finger. The urethra was correspondingly elongated. The urine was fetid and loaded with pus and mucous, which was deposited in the receptacle as a thick gelatinous mass. His pupils were contracted unequally and the tongue was furred. He was prepared for operation, and under nitrous oxide anesthesia a high cystotomy was performed. A peculiarity that was noted was the difficulty of drawing the guide downward far enough to bring its end within the *cavum Retzii.* This was due to the enormous size of the prostate, which had undergone general hypertrophy. There was no irregular projections. The bladder was thoroughly irrigated, its anterior surface stitched to the abdominal wall, and the operation completed by introducing a large drainage tube and packing the viscus with iodoform gauze. He was conscious before he was lifted from the operating table and laughed at his former dread of the operation. Time under anesthesia, twenty-three minutes. He had no shock, nausea or vomit-

ing. When I called the next day his first exclamation was: "Doctor, I've forgotten all about my bladder." All tenesmus had subsided. With the usual irrigation with *Boric acid* solution, four times a day, the urine became normal, and in three weeks he could retain it without dressings or apparatus of any kind, passing it at will through the supra-pubic opening. At this time having gained in flesh and being able to sleep well, he returned to his office. At the present time (four months after operation), digital examination shows that the prostate is very much decreased in size. He is perfectly comfortable, passing the urine once in three or four hours during the day, and getting up once or twice at night.

McGuire, Bangs, Myer and Otis have invented elaborate apparatus to wear in this suprapubic opening to prevent leakage, and so far I believe none have proven perfectly successful. My patients have no trouble with leaking and they wear nothing except during a period varying from ten days to three weeks after operation. The urine is voided voluntarily through the fistula, or a catheter is introduced with sufficient frequency to prevent closure. The most that is required is occasional dilatation. I saw one patient (operated by an eminent genito-urinary surgeon) who wore a tube in his bladder for two years and a half. And during this period he was an invalid confined to his room most of the time, suffering from all the symptoms of a foreign body in the bladder—constant aching and soreness and ceaseless tenesmus vesicæ. I had the tube removed permanently, the symptoms promptly subsided and he was soon able to resume his business.

Many of the same general measures previously mentioned are applicable after operation. I believe it is wise to pass the catheter through the urethra just as little as possible in the after treatment; for most troublesome irritability may be again lighted up, and this leads to the reflection that for the same reason, a perineal section may be fruitless. The prostatic spasm may render drainage through the perineum imperfect or even impossible. At the first glance this would seem to be the ideal method for permanent drainage, but it has been shown that drainage is not perfect even in younger subjects without irritable prostates. And another imperfection in this method is that the perineum may be so thick, especially in gouty subjects, that the finger cannot palpate the interior of the bladder nor manipulate instruments in removing prostactic projections. There are times, though, when the perineal and supra-pubic incisions may be combined with advantage, and when both are done at once it will generally be found that the high incision affords the better drainage. When prostatectomy is contemplated, therefore, the supra-pubic route is, to my mind, the one to be preferred. Its mortality rate is not now regarded as any higher than that of perineal section and it manifestly possesses more advantages, even for permanent drainage alone. In many of these latter, as good results have been obtained by permanent drainage as by prostotomy or prostatectomy or any of the combined methods. It must not be inferred from this that I am seeking to disparage these operations or that I am in favor of vesical paracentesis. The latter does not favorably appeal to my judgment. We know what plunging a trochar through the perineum into the bladder, with subsequent drainage, has been followed, in some cases, by good results; but it is a procedure of limited scope. The prostatic atrophy ensuing after tunneling cannot be in excess of that following incision, and the latter possesses the merit of permitting a thorough examination of the bladder and facilitates prostatectomy if necessary. I advocate incision because it has greater possibilities. I deprecate tapping because it is not in keeping with the most advanced surgical thought. I am not an advocate of blind plunges or under-ground surgery. Of all the methods, either singly or combined, none has afforded more relief and none offers so great a scope for carrying out various necessary measures as the supra-pubic incision. .

Castration, as suggested by White, to induce atrophy of the prostate gland seems to me to be quite logical and worthy of consideration, but will meet with much opposition before it becomes popular. I suggested it to one man, sixty-eight years of age, and suffering from prostatic hypertrophy and who had been impotent for years, and he treated the suggestion with scorn.

The few reported cases in which castration was resorted to for the relief of prostatic hypertrophy were followed by relief, but not at once. In desperate cases, where immediate relief is necessary, it might be advisable to consider cystotomy with castration. A few cases of Bier's method of simultaneous ligation of the internal iliac arteries have been reported, but the procedure is, as yet, in its experimental stage and judgment should be withheld for a time.

Finally, I wish to plead, first, for early diagnosis; second, instituting local treatment, as outlined in case I; and third, operation, as soon as well conducted local and medical treatment fail to relieve the frequent micturition. It is well known that no renal structures are calculated to withstand the effects of frequent and long continued retro-ureteral pressure attending troublesome prostatic hypertrophies, not to speak of the general wear and tear due to suffering and loss of sleep. So that, without considering the patient's misery at all, all the indications point with imperative necessity to operation. As Lydston well says: "There is no reason why such cases should be allowed to suffer indescribable torture and to die finally as burnt offerings to a conservatism that conserves nothing but a dangerous routine, let-alone-policy which has no place in the surgery of today."

INCARCERATED HERNIA.

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Webster says that incarcerated hernia is a "constriction about the hernial sac or elsewhere, in cases of hernia, which does not admit of being easily reduced. Strangulation, as in hernia, etc."

Thomas defines it as "a term applied to the portion of bowel, or other substance confined by the stricture in strangulated hernia." These definitions are too comprehensive, as they may cover irreducible, obstructed, and strangulated hernia; most writers, however, reserve for incarcerated hernia the first two divisions, but as the word means simply to imprison, the latter may be included as well. Thus, the term incarcerated implies:

1. That the hernia is irreducible;
2. That it may be obstructed;
3. That it may be strangulated.

I believe the term to be an indefinite and unfortunate one, which should not be retained in our nomenclature. I would use instead the three specific terms just mentioned. What do we understand by irreducible hernia, obstructed hernia, and strangulated hernia?

I. IRREDUCIBLE HERNIA.

It is my opinion that a hernia should be considered irreducible when it resists for fifteen minutes skillful taxis, with the patient under an anesthetic. I am aware that in this I differ from most authors, and I will give my reasons later.

The intestine may be rendered irreducible by adhesion to the sac, or by atrophy of the hernial mass where it passes through the neck, accompanied by thickening of the contents of the sac; this is frequently the case, especially in omental hernia. Permanent enlargement of the tissues of the tumor is caused by deposits of fat, and by fibroid or glandular thickening. Temporary irreducibility may be due to distention of the intestine with gas, fluid fecal matter, or the extrusion of an unusual amount of the abdominal contents, as well as by muscular contraction of the ring or inflammatory thickening of this structure. These conditions may quickly disappear, but frequently the symptoms become greatly aggravated, and the case passes on to obstruction, strangulation, or both. Occasionally we meet cases in which the hernia comes down, and is readily returned by the patient; this descent and replacement may continue for months or years, and finally the subject finds little inconvenience from the unreduced hernia and the truss is left off altogether. After a time, either from adhesions, or some of the other causes, the mass cannot be returned at all; and then it becomes a chronic irreducible hernia, and is a constant menace to the life of the individual. Such an one is not safe a single hour when beyond reach of the surgeon's skill.

II. OBSTRUCTED HERNIA.

This may be present in the reducible, irreducible, or strangulated varieties. It is due to the inability of the peristalsis of the intestine to force its contents through the knuckle that is bent up in the hernial sac. As Mudd says: When this condition is present without strangulation, it is usually slowly developed. Constipation is present, the abdomen becomes gradually distended, eructations of gas, associated with borborygmus, but without any escape of flatus per rectum, attest the severity of the obstruction. Vomiting, which finally becomes fecal, completes the group of symptoms, and often renders it difficult to separate this condition from that of strangulation.

III. STRANGULATED HERNIA.

This is obstruction to the return circulation from the whole or a part of the constricted loop of intestine, thereby the mass is exposed to the dangers of gangrene. In this form of hernia we may have both of the foregoing divisions of our subject, irreducible and obstructed hernia, co-existing with the strangulated variety.

Treatment.—There are but few conditions which require more thorough and intelligent treatment to conduct the case to a satisfactory termination than the one under consideration. And I may add that but few diseases are susceptible of more gratifying results than these, provided the right thing is done at the right time. But the golden opportunity must not be lost in the so-called medical treatment of hernia. I do not know of any procedure which is directly responsible for so many deaths, as the use of medicines in incarcerated hernia. I know that there is at least one most excellent surgeon who believes in, and teaches the use of, medicines in some instances, and claims to have had good results. But the only unsuccessful cases of hernia that I have ever seen, were treated first by the use of such remedies as *Nux vomica, Veratrum, Opium, Rhus tox*, and *Sulphur;* or by the equally inefficient plan of the old school, which comprises hot baths and fomentations, blood-letting, antimony, enemata, especially of tobacco, which makes the patient deathly sick and thus causes relaxation. Why do we waste time and lose valuable lives by the use of treatment, which, in ninety-nine cases out of one hundred is impotent to do any good, and often places the patient even beyond the resources of surgery, when we can command the use of such powerful and safe remedies as *Chloroform* for relaxation, and the knife to relieve constriction? Let us learn to throw aside all of these so-called auxiliaries, which so often cause dangerous delay and loss of life by gangrene or its effects.

Another plan of treatment which may cause irreparable harm is undue taxis. I myself have seen three cases of strangulated hernia with gangrene, in which the loops of intestine were ruptured, and the fecal contents had not only escaped into the sac and peritoneal cavity but the tissues of the hernia and round about it were so contused that serious phlegmon developed and forbid successful surgical treatment. Even if the injury and neglect are not so deadly the violent taxis may produce ecchymosis and softening of the hernial contents, and the success of subsequent operation is rendered very doubtful. Often strangulation occurs in a long-standing hernia, which the patient has been accustomed frequently to replace. In such cases taxis has been performed by the patient himself to an alarming extent, before the surgeon arrives, and if he adds to the traumatism by repeating the taxis, the case may prove serious indeed. Modern experience teaches that it is poor practice to waste much time in the use of hot baths, fomentations, elevation of the heels of the patient, or any other so-called adjuvant, because we cannot be positive that destructive changes are not taking place in the intestine, and that the delay caused by the employment of uncertain treatment will not bring about a fatal result. The safest course is at once to resort to taxis, and if the case promises to be stubborn, give *Chloroform* with the understanding that a failure at reduction will be followed immediately by operation.

Manipulation under an anesthetic should not be employed for more than fifteen minutes. If this plan were followed there would be but few, if any, cases for anastomosis, enterorrhaphy, or artificial anus; and consequently but few deaths would be reported, as the mortality of herniotomy would not be over one per cent. I am aware that it is higher, but it is because the operation is left as a *dernier resort*, and congestion, œdema, softening or rupture of the intestine, accompanied by gangrene and phlegmon, has often taken place. These conditions in the majority of cases are due to long delay, application of inefficient treatment, or, what is much worse, inordinate taxis. Deaths from the above causes do not result from herniotomy, but because this operation is not performed in time. If we would be successful in the attempt to rescue our patients from the imminent dangers of this disease we must rid ourselves of the old fears which clustered about this operation up to twenty-five years ago. We must expel from our minds that operations upon and about the peritoneum are such dangerous procedures. Every ordinary herniotomy is but little more than a clean incision, and the great improvement in the treatment of wounds has well nigh robbed it of danger. This

fact, coupled with the radical cure which follows in a large percentage of the cases, ought to enable us to decide in favor of early and thorough operations.

Exploratory abdominal section, in itself, has almost no mortality; ovariotomy by the best operators is down to three or four per cent; and vaginal hysterectomy, in suitable cases, has but five per cent. The wonderful improvement in the surgery of today is more marked in every other field than in the subject under consideration. I have carefully examined the available surgical literature which has issued from the press since 1812, and it is indeed strange to note that until about five years ago but little progress had been made in the treatment of hernia, since the days of Dupuytren and Cooper. Now much is written upon the subject. We are beginning to regard herniotomy not as the last resort, but as a life-saving procedure, and the question is not so much what kind of an operation, as how early shall it be performed.

I do not wish to be misunderstood as to when I would operate for hernia, for I don't believe we would lose more than one per cent if the following rules were observed:

1. Regard hernia as a mechanical condition, and always treat it as such.

2. Educate the profession to look upon operative procedures as the most important part of the treatment in all obstinate cases.

3. Lose no time in the application of judicious taxis; if this proves unsuccessful, administer *Chloroform* and repeat it.

4. Do not prolong the taxis under an anesthetic beyond fifteen minutes duration, and use great care not to injure the parts.

5. Bear in mind that a clean incision is not half as dangerous as a contusion and its results.

6. If, for any reason, herniotomy cannot be performed as soon as taxis under *Chloroform* fails, do not lose more than twelve hours in the preparation for the operation.

7. When the case has been neglected and gangrene has taken place in the intestine, the degenerated portion should be immediately excised, and if the calibre of the two ends be equal, choose between enterorrhaphy and anastomosis. If, when the gangrenous portion is removed it is found that the patient cannot withstand a longer operation it is better to form an artificial anus by the stitching of the two ends of the intestine into the wound, then if sufficient improvement takes place, restore the continuity of the intestine by a second operation.

8. If there is great disparity between the ends of the divided gut, which is sometimes the case, anastomosis is indicated.

9. If a portion less than the whole intestinal tube of not more than one or two inches in length, opposite the mesentery is gangrenous, excise the devitalized part in a V shape piece so as to leave the mesenteric portion of the healthy gut uncut, and suture the peritoneum of the two borders of the cut surfaces so as to form an elbow in the intestine, with a free passage between the sutured portion.

10. Where from long obstruction of the canal fecal toxemia is imminent, form an artificial anus until this danger subsides, then restore the continuity of the gut by enterorrhaphy or anastomosis.

Dr. Alvin S. Butler, one of the organizing spirits in the National Homeopathic Medical College, died on the fifth of last month at the age of fifty-six years.

SURGICAL DETAILS—HOW TO PRODUCE ANESTHESIA.

By ALBERT G. BEEBE, A. M., M. D., Chicago.
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I concluded a former paper in the Medical Century of May 15 by saying: "As one item of surgical detail of the utmost importance, I should like sometime to discuss briefly the management of the anesthetic, as upon this depends, to a large extent, the comfort and safety of the patient as well as the convenience of the surgeon." Much has been written and said as to the theoretical aspects of this subject but my purpose is to consider it purely in a practical way and from the standpoint of experience and give, as briefly as I can, my own conclusions as to the best and safest way to secure surgical anesthesia. I shall not take the time or space necessary to give all the reasons, though there are, as I think, abundant reasons to sustain each one of my conclusions.

The Anesthetic—The first point is as to the selection of the anesthetic. The choice lies practically between *Chloroform* and *Ether*. Others have failed to maintain their claims to superiority and have dropped out of sight or have not as yet been sufficiently tested, perhaps, as in the case of *Nitrous oxide*. *Chloroform* has many obvious advantages. My earlier experience was altogether with this agent; but I was soon compelled, both by my own experience and by the growing condemnation of its use by professional and public opinion to abandon it as being much too dangerous, while safer means were at hand. However carefully it is handled, and however skilfully, it is undoubtedly treacherous and dangerous. I speak now of its use in surgery. In obstetrics it has never, I believe, been known to cause death when properly used (except possibly in a single doubtful instance) and in view of its many advantages I should never use any other anesthetic in the lying-in room, and seldom deny the patient there its benefits.

But in surgical practice the case is quite otherwise. Infants and young children are comparatively exempt from its dangers, and as they take *Ether* very poorly I usually give them *Chloroform*.

When we turn to *Ether* alone, we find it much safer, but slow and much more difficult to secure complete anesthesia, at least with the ordinary methods and apparatus, the amount usually required often amounting to a pound or more, very seriously depressing the patient and producing distressing and protracted nausea and prostration. This undoubtedly often destroys whatever chances of recovery the patient might otherwise have. A careful study of these two agents has convinced me that the action of *Ether* should neutralize the dangerous action of *Chloroform*, i. e., the cardiac paralysis and syncope. I therefore decided to combine them. The old A. C. E. mixture had been recommended and used by a few, but with no very satisfactory results. I could see no advantage in diluting the mixture with *Alcohol*, and therefore fixed upon one volume of *Chloroform* and three of *Ether* as being about the proper proportion, and have now used this mixture for some fifteen to twenty years, *exclusively* (except as above noted), and I cannot recall a single instance in which it has ever produced alarming or dangerous symptoms, or in which any restorative measures were called for. It seems to have all the safety of *Ether* and all the ease of administration and freedom from distressing sequelæ of *Chloroform*. In short, it seems to me the most perfect anesthetic we have yet found.

If properly administered, two to three ounces of it will maintain full anesthesia in an adult for an hour.

Administration—The mode of administration is also a matter of the greatest importance. My practice is invariably to give the anesthetic myself until the patient has lost consciousness. It is, I know, entirely the custom to delegate this duty to an assistant, and often to those who are far from skilful or experienced. This seems far too important a matter to be treated in this way. In the first place the patient will surrender himself much more willingly and confidently to the surgeon than to anyone else, because he trusts him most thoroughly as the most skilful person available. *Very much* depends upon this entire confidence and freedom from anxiety or fear on the part of the patient. The preparations should be made entirely out of the patient's sight and hearing, and the patient kept as cheerful and undisturbed as possible. In all cases the anticipation of an operation should be made as brief as may be, and all apprehension or dread removed as far as possible.

As a rule I prefer, especially with nervous or timid patients, to commence the anesthetic while they are still in bed in another room, and have them returned to it again before awakening, thus getting rid entirely of the horror of the operating room and table. If the patient is weak or the operation likely to be protracted or exhausting I think it advisable to give half an ounce or more of whisky or brandy with as much hot water half an hour at least before commencing the anesthetic. It also gives him courage and favors the anesthetic effect. In many cases also, if there is reason to expect much pain after the operation, a hypodermic dose of one-fourth grain of *Morphia* may be given about fifteen minutes after the stimulant or instead of it. In abdominal operations, of course this should be avoided or one grain or more of *Codeine* substituted, so as to avoid the paralyzing effect of the opiate upon the intestinal tract.

Inhaler—The inhaler may be one of several, always provided there is free ingress of air. Allis' is good, but seems to me to be wasteful of the anesthetic. I use one of my own, about the same shape as that of Allis', made of rubber (leather would probably do quite as well), but instead of the open top of Allis' instrument mine is closed and has a valve to admit air freely. It is lined with spongeo-piline and partly filled with surgeon's gauze.

Everything being in readiness the patient should be approached as pleasantly and unconcernedly as possible and assured that there is nothing to fear. That if he will give himself up to it willingly and without resistance he will float off into slumber as pleasantly as a baby going to sleep in its mother's arms. He is allowed to examine the inhaler and assured he will not be strangled by shutting of his supply of air, etc. A drachm or two of the mixture is poured upon the gauze and lining of the inhaler and it is then gradually inverted above his face, but *at least six inches away*, so that he just gets a faint whiff of it for a few inspirations. As he gets to breathing it easily and naturally, approach it *very cautiously* and gradually nearer, but never so as to produce coughing or a sense of suffocation.

This very gradual and gentle commencement of the anesthetic is the most important part of the whole procedure. I wish to emphasize this as strongly as I can for two reasons. First, the safety of the patient depends upon it. Where so profound an impression is to be made upon the brain and nervous system as this, it is of the utmost importance that it be produced gently, gradually and without excitement. Nothing could be worse or more dangerous than a sudden and violent onslaught and yet this is what we usually see wherever anesthetics are administered. Second, the comfort of the patient (and the surgeon and his assistants as well) depends upon it, for when this course is pursued the patient will almost invariably lapse into insensibility without a word, a sound or a struggle, and when the anesthetic is withdrawn will awaken in the same way. When unconsciousness has been fully reached he is placed upon the operating table, the assistant selected takes charge of the inhaler, and by the time the operator has made his last preparations the anesthesia is complete. When that stage is approaching the fact should be borne in mind that the effects of the anesthetic do not develop immediately upon its inhalation, and if it is pushed steadily up to the time of profound anesthesia and then withdrawn, the effect will continue to develop for some minutes longer, and thus a dangerous degree of narcosis may be produced after the inhalation has ceased. This stage should therefore be approached cautiously and then maintained by steadily administering just enough to keep the patient quiet. The mistake is often made of stopping the inhalation entirely until the patient begins to rouse up, then crowding it on again, and so on alternately from dangerous narcosis to half sensibility, but never just right. Unless there is some urgent necessity for rousing him the patient should, after the operation, be returned to his bed and allowed to sleep as long as possible, provided there are no unfavorable symptoms. During the period of recovery I can add little to the usual measures, such as quiet, keeping the head low, etc., except the judicious administration of hot broths, etc. (rather than ice), to quiet the stomach, and to relieve the exhaustion from the fasting—often unnecessarily protracted before the operation—as soon as it may safely be done.

Let me recapitulate briefly the points to be emphasized:

1. The anesthetic—one volume *Chloroform*, to three of *Ether*.
2. Secure patient's confidence and coöperation.
3. Commence slowly and gently.
4. Give air freely with the anesthetic.
5. Avoid the cumulative effect.
6. Continue it evenly and steadily.
7. Allow quiet after-sleep.

ADULT HYPOSPADIC HERMAPHRODITE.

By J. WYLIE ANDERSON, M. D., Denver, Colo.

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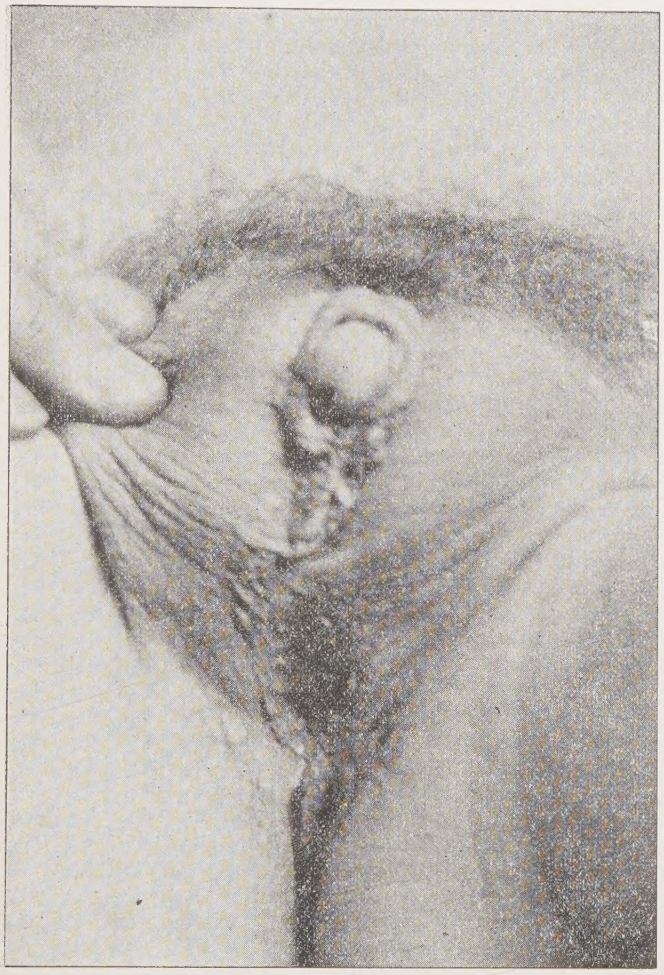
The subject of this article is twenty-four years of age, born in Vienna, of German parentage, the twelfth child. Weighs 130 pounds. Five feet 6½ inches in height; was dressed as a man. Shoulders were broad like a man's; hands large like one used to hard labor; feet smaller than usual in one of his size; hips not overly prominent; voice could be taken for male or female, not characteristic of either sex; no beard upon the face, looks and feels as smooth as a girl's; mammary glands large and well formed as any woman's; nipples prominent; on viewing the breasts one would undoubtedly decide at once they belonged to a well developed woman.

Next we note that the mons veneris is that of a female. By reference to accompanying illustration, you will observe what resembles the glands penis (about the size of a boy's of the age of eight years),

somewhat rudimentary in size, which is imperforate, and about one inch long; the prepuce just back of the gland passes down and is split on under side and ends on each side in a well defined labium minus; at the posterior part of which at (A) an inch and a quarter from under side of enlarged clitoris or glans penis is the opening of the meatus urinarius.



The labia majora were well developed as seen in the illustration marked (B), within each was seen and felt a large well developed testicle. Next at (C) we observe the orifice of the vagina. The vagina is not more than an inch to an inch and one-quarter in depth, ending in a blind pouch, to which no uterus is felt. I made an examination with the finger per rectum and could detect neither uterus or ovaries; as I was not permitted to pass a sound into the urethra my examination was not complete, but I am convinced if the uterus and ovaries exist at all they are rudimentary.

A few interesting facts about this anomalous case. The penis, which I have described as being one inch in length, was supplied with erectile tissue and when excited enlarged in size and increased in length to one and a half inches, curving downward and slightly to one side. On being asked if menstruation took place, he, she or it stated that it had nose bleed every four to six weeks; sometimes the hemorrhage would be only on one day, again recurring once or more times for two days. At times quite profuse. During these times it had a sense of fullness in the lower part of abdomen. Coming as it did quite regularly, could this not be considered vicarious menstruation? On inquiry it was ascertained that at times it had nocturnal emissions, associated with erratic dreams of the female, and they were accompanied with a clear, watery discharge. The question arose in my mind that inasmuch as it assumed the dress of the male might not that through the law of association account for dreams of the female sex?

On urinating it assumed the sitting position the same as a woman.

I had the pleasure of displaying this interesting clinical case under the section of surgery May 18, 1894, during the meeting of the American Institute of Homeopathy at Denver, as those present will remember. I am indebted to Dr. H. C. Aldrich of Minneapolis for the photo used in this article.

Materia Medica.

WHAT THE HOMEOPATH SHOULD KNOW OF DRUGS.

BY JABEZ P. DAKE, A. M., M. D., NASHVILLE.
EX-PROFESSOR OF MATERIA MEDICA, PHILADELPHIA, 1855-6-7.
EX-PRESIDENT AMERICAN INSTITUTE OF HOMEOPATHY.

The quality and extent of knowledge that the physician accepting the Homeopathic principle, should possess concerning drugs, has been discussed by every writer and teacher of Materia Medica, from Hahnemann down, and yet the question seems not fully settled. In this brief communication I propose to do little more than to indicate the general bearings of the inquiry with some reference to practical duties on the part of the physician and teacher. In general, I think the tendency has been to take too circumscribed a view of the part to be performed by the Homeopathic practitioner, as if his one and only duty were to make a comparison of the drug symptoms on the one side with the symptoms of the case to be cured on the other, in order to discover a similarity. Such a view overlooks the fact that, the Homeopathic physician, like all others, is liable to be called in cases of poisoning, where antidotes are needed, and to cases of self limited or necessarily fatal affections which require only palliative measures. It needs no display of facts or argumentation to convince one that attendance upon such cases calls for a knowledge of drugs not especially needed in following out the Homeopathic principle, and that a knowledge quite different from that of ordinary symptomatology is necessary to be used upon chemical, mechanical or antipathic principles.

We cannot imagine a physician who is entirely limited to the Homeopathic use of drugs. He may turn a deaf ear to calls in cases of poisoning, but he connot tell when he may have cases in hand demanding palliatives instead of Homeopathic remedies.

Our friends on the other side have erred greatly and done our practitioners gross injustice in saying that the Homeopath must and can go no further in the use of drugs than the law *similia* bids him go, and that he is trespassing upon their domain whenever he attempts to do so. His recognition of the Homeopathic law does not signify that he is any the less a physician in general, but, rather, that he is more amply qualified to contend against human ailments in all forms and by all means. The conclusion is forced upon us, then, that whatever information as to the powers and uses of drugs the work of the physician requires he should by all means possess.

Omitting much of the technical knowledge that belongs to the pharmacist, we are safe in saying that the Homeopathic physician should know:

1. The physical or scientific characteristics of each drug he is to employ, so far as to be able to identify it when necessary.

2. Its poisonous or destructive properties, absolute or conditional, together with its antidotes, chemical or otherwise.

3. Its pathogenetic effects in the human organism when used in definite but not really poisonous quantities.

4. Its stimulant, anesthetic, soporific, or other palliative influence when used in certain quantities and ways

To enlarge a little I would say that the physician, while obtaining his remedies chiefly if not altogether from the pharmacist and trusting largely to his capability and faithfulness, should be able to recognize the original articles and understand something of the treatment they must receive to fit them for his use. Drugs of any considerable power are all more or less poisonous and it is not always easy to draw the line between the poisonous and medicinal doses. The difference is one of quantity and degree and not one of kind. In gathering up the pathogenesy or positive effects of a drug the writer of Materia Medica must cull from cases of poisoning as well as from provings purposely made. He thus gets the more violent or deeper effects as well as the more ephemeral. But the essential point, in all gatherings expected to be reliable and useful to the Homeopathic physician, is to have facts and not fancies. If the records of symptoms observed in cases of poisoning have been badly made, or if the experimental provings have been carelessly conducted so as not to exclude vitiating influences, the pathogenesy must be far from reliable and useful.

It is undoubtedly the duty of the Homeopathic physician to know what the effects or symptoms produced by his drugs are, not in persons sick already but in persons otherwise well.

But he is subject to a delusion and a snare if he imagines that he will know them when he has committed to memory all the symptoms in the "Materia Medica Pura," in "Jahr's Manual," the "Encyclopedia of Pura Materia Medica," or in the "Cyclopedia of Drug Pathogenesy." It is a lamentable fact, shown indisputably by the higher medical criticism, that the sources of impurity, the gateways to the realms of imagination, misapprehension and even fraud were not all shut while the drug pictures were being taken.

Applying the rules of evidence to the witnesses whose testimony constitutes our Materia Medica we must realize that very few of them have come up to the standard requiring "the truth, the whole truth and nothing but the truth" concerning drug effects. Exhaustive provings, conclusive as to the full range and power of any one drug, we do not possess; nor an we pride ourselves on having the pathogenesy of any one drug entirely free from spurious symptoms. And, yet, the information we have gathered and confirmed by clinical experience enables us, and enabled Hahnemann, under the law *similia*, to accomplish in the treatment of the sick what could not be accomplished by the highest knowledge of the old style Materia Medica. While doing practically the best he can with present light the Homeopath looks forward to a time when his knowledge of the properties and powers and, so, the uses of drugs will be more complete, less vitiated and more in keeping with the demands of his therapeutic law.

In conclusion it should be said that the Homeopathic student should be taught not only the symtomatology as required in Homeopathic practice, but likewise the nature and uses of drugs as stimulants, palliatives and antidotes and how to meet any of their effects as poisons.

Practice of Medicine.

LOCAL TREATMENT IN DIPHTHERIA. A WORD TO "PROGRESSIVE" HOMEOPATHS.

By MARTIN DESCHERE, M. D., New York.
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The treatment of diphtheria is the apple of Eris in the discussions among Homeopathic physicians.

There are the ultra-Homeopaths of the high potency wing who try to be even more catholic than the pope, and who see the alpha and omega of curing disease solely in the administration of a single dose of an arbitrary high potency.

Next there is the conservative element, men who in full conviction of the truth of Hahnemann's teachings hold to them conscientiously, without being biased by one extreme or the other.

The third variety is composed out of self styled "Progressive Homeopaths," who parade with the glittering assertion of combining the modern achievements of medical science with Homeopathic treatment. Soporifics, purgatives, antipyretics, and antiseptics, of all possible variations, but always the "latest in the drug market," are placed by them at the disposal of their patients; for they claim to be "physicians first," and they will never permit a human being to suffer for the sake of a "doctrine," or a "pathy."

They consequently favor adjuvant treatment and local applications wherever possible, and naturally so in diphtheria.

They boast of "common sense" treatment, of the "utter necessity for cleansing the affected parts," of "disinfecting to prevent fatal sepsis," etc., *ad infinitum*. The warning from the side of the high potency and the conservative part of the profession is rejected as antiquated and narrow-minded. The greater success, as claimed by strictly constitutional, pure and simple Homeopathic administration of drugs, is credited rather to errors in diagnosis. For "infallible" authorities in pathology and bacteriology have given their dictum as to the incurability of certain forms of diphtheria; ergo, these dare not be cured, and if such cases are reported with favorable results there must be a screw loose somewhere.

As long as these progressive gentlemen will not listen to the criticism of their conservative brethren, but only to their authorities of old school fame, they may perhaps take more kindly to the proclamation of one, who certainly stands foremost among the latter as an expert in diphtheria, Dr. Abraham Jacobi, of New York.

In an admirable address before the recent International Medical Congress at Rome, entitled: "Non nocere," this gentleman gives the fruit of his experience in the disease in question, after thirty-six years of practice, in the following forcible and noteworthy manner. (N. Y. *Medical Record*, May 19, 1894.)

After enumerating some of the dangers in diphtheria, he continues: "The fourth great danger in the worst forms of diphtheria is the over-officious and directly detrimental exertion of the attending physician in behalf of *local treatment*.

"It is true, where the diphtheritic pseudo-membrane is within reach, it ought to be either destroyed or disinfected. This is not the place to discuss the methods and the remedies. *But we must never forget, first, that only a small part of the pharynx is*

directly accessible to such treatment, and that it is only one class of patients who can be subjected to it. In order to be effective the application must be thorough. None but adults or grown up children, and of them *only a small number*, will submit to opening their mouth and having applications made. It is that very class of patients only who can be induced to gargle with anything like success, though indeed, gargling will reach only the oral cavity down to the anterior pillars of the soft palate. Smaller children will object, will defend themselves, will struggle. It takes many a good minute to force open the mouth; meanwhile *the patient is in excitement and perspiration, he screams, he fights, and exhausts his strength.* You may, however, succeed in forcing the jaws; then begins the practice of making applications, of swabbing, of scratching off the pseudo-membrane, of cauterizing, of burning. *The struggling child will prevent you from limiting your application to the diseased surface. You cannot help injuring the neighboring epithelium; thus the process will spread; instead of doing good, you have done harm. No application, indeed, can do as much good as the struggling of the frightened child proves destructive.* Even the intervals between the medical assaults are no period of rest to the tortured baby, whose fears result in constant mental and physical trepidation. I have seen them dying in defending themselves against the attempted violence, leaving doctor and nurse victorious on the battle-field. It is incredible, but it is true, that more than one has recommended the use, after forciby separating the jaws, of the electro-cautery, or the thermo-cautery on the throat of the baby. It is incredible, for you are aware that the offenders cannot have been, or ought not to be, ignorant of the fact that what they can reach with their instruments is but very little besides the tonsils, and they might have known that the tonsils are not apt to favor the invasion of general sepsis. *Why, then, insist upon these cruel and brutal exertions, most of which are discovered and advised by men possessed of a schematic knowledge of a pathological process, which leads them to kill their patients while trying to destroy a baccillus. 'Le sujet est mort, mais il est mort gueri.'* There is no excuse for them, for there are a great many ways in which an antiseptic treatment of the fauces can be carried out, by the frequent administration, both with internal and local effect, of mild doses of medicines, etc. * * * On no condition must a child be taken out of bed for the purpose of having the nares washed and disinfected. I know of many cases in which the patient has thus died through being taken up by either nurse or doctor. * * * As I have personally seen thousands of innocents die of diphtheria, thousands of them in the course of thirty-six laborious years, therefore, with trembling heart, I know whereof I speak; and still they are dying by the hundred thousands all over the globe, and that is why I preach my old sermons."

"*Non nocre.* Do no harm, and permit no harm."

Thus far Jacobi. At the same time it is curious to observe, how, in this very article he advocates local disinfection in *nasal* diphtheria. But are the inner recesses of the naso-pharynx of easier accesss than the fauces? Do the patients struggle less during these applications than while being attacked through the mouth? They may be more somnolent; or they may be not. And is not this very somnolence a strong evidence that sepsis has already taken place? Are the tender tissues of the nares less vulnerable than the mucous membrane of the mouth? Are not thus new gates opened to sepsis in this instance as in the other?

Let us be consistent. Local treatment in diphtheria is "*cruel and brutal,*" as Jacobi justly says, *wherever applied.*

It is for those very reasons of cruelty, brutality, harmfulness, and utter uselessness that I raise my voice against such treatment, which is doubly unbecoming the Homeopathic physician, the existence of whom is justified only by executing his proclamation before the world that his results, in combating diseases, supercede those of all other methods of treatment; on account of his following a law of cure, which enables him to administer a remedy, which, by physiological test proves capable of restoring the diseased organism back to health, without submitting the suffering child to the antiquated, cruel and dangerous methods of the old school of medicine.

Progress! By all means, progress! But let us do so in the right direction. Homeopathy is the science of drug therapeutics. On this line we have to perform our honest work. Here our duties are plainly marked out. Here we have a debt to pay; for our stock of material for therapeutics, our Materia Medica, needs many additions, corrections and verifications. Do you call it progress to cast aside this, your legitimate material, and to grasp at deceptive, denounced methods? Methods denounced by men who have tested them to their horror and disgust? By men, whose very reliance was founded on local treatment of diphtheria, which was forced upon them by a logical process of reasoning, from their premises? But as their premises are false, so must be the conclusions, the result; and so is the result. The condemnation of local treatment in diphtheria is a declaration of the incompetency of the dominant school of medicine to successfully combat this disease, following their bacteriological theories.

There is certainly a great difference, whether such a statement is made in private conversation, by a physician of doubtful knowledge and experience, or whether it forms the subject of an erudite essay, presented before a convention of the leading physicians of the world, by one most thoroughly competent in this question, one who has grown gray in practice, who stands forward as a teacher in diseases of children, whose counsel is valued by his professional brethren, and who has made diphtheria a special study of his life.

Therefore let us do better. Let us bring to bear the forces at our disposal. As long as we possess the means in our well proved drugs, which have been amply verified by clinical experience, let us make full use of them. There is no question that we have won laurels for Homeopathy in the treatment of diphtheria. But we must not expect too much. There will always be cases which, notwithstanding the most ardent efforts of the physician, will prove incurable. Many uncontrollable causes may act, singly or in combination, from the malignancy of the infection to the want of resistance of the patient, against which our present knowledge is insufficient. It would be unjust to blame the method for our shortcomings. As far as experience teaches there is no better treatment for diphtheria in all its forms than the *pure Homeopathic method*, unadulterated by local applications, or other ajuvant treatment, for it is all-sufficient. The physician who, after a careful selection of his remedies, a strict adherance to the laws of hygiene and diet, which are of vital importance in this dangerous affection, has been incapable

of saving human life, may rest assured that he is not guilty of any omission. He has done the very best which science in its purest sense enabled him to do.

But I cannot close without warning most emphatically against the belief that you have given the "indicated remedy" by simply administering some drug which has been found highly useful in many other cases and because it has been so found. Always make it your sacred duty to individualize most carefully before you select the remedy. That alone insures success here as everywhere.

The Century Clinic.

Dr. Rule's Labor Case.—Dr. Rule asks for criticism of his management of a case of labor, in the July 15th CENTURY. In my opinion there was too much drugging and too much delay in delivering. In the absence of expulsive pains forceps should have been used (after rupture of membranes) as soon as os was dilated, or, failing with forceps, turning should have been resorted to. In many cases of twin pregnancy the uterus is paralyzed by over distension and needs mechanical and not medical relief. Nature is even incompetent in some such cases to complete dilatation.

Dr. Rule intimates that he was not "allowed" to use forceps. This should have been insisted on, or no responsibility assumed. I do not think he would have been troubled with hour glass contraction and subsequent hemorrhage had he operated early, before the uterus was tired out and irritable.

A few years ago I was called to a case of twin pregnancy. Dilating pains were unsatisfactory, the os, in two days, only opening to the size of a half dollar. Finally, as there was a midwife in attendance, I left word to have them call me a few hours later if no further progress was made, when I purposed to dilate and deliver. Kind neighbors, however, advised them to send for another doctor, who told them I would be liable for malpractice if I should deliver under the existing conditions. He inserted forty grains of *Chloral* into the rectum and left her in charge of the midwife. Labor was completed two days later, and children and mother were lost. I have little doubt that timely interference would have saved the mother at least, and probably children as well. JOSEPH LEWIS, JR., M. D.

Milwaukee.

In Re Vaccination. Under the above head, in your issue of July 15, Dr. E. S. Ayres asks, "Wonder who'll knock me out in return?" He had said: "Cowpox is smallpox attenuated by passing through the bovine race." Important if true, but it is not true. Chauveau made a series of elaborate experiments on cows in that direction, and in his paper before the French Academy of Medicine, October, 1891, reports: "(1) Vaccine virus never gives smallpox to man; (2) variolic virus never gives vaccinia to the cow; (3) vaccine is not even attenuated smallpox." Dr. Ayres also says: "Varioloid is smallpox modified by a previous attack of itself or by vaccination." Varioloid is nothing more than a mild form of smallpox, often occurring entirely independently of previous attack of smallpox and in unvaccinated persons. The term varioloid is simply a subterfuge invented in Jenner's time to fool the people with, and with which to apologize for the fact that vaccinated persons were having smallpox, and just as numerously as did the unvaccinated. The regular statistics for many years as well as right now show that of the smallpox patients at least seventy per cent had been vaccinated, some many times. The ideas of revaccination and modification which Dr. Ayres alludes to are simply *ignes-fatuii*, quibbles which have grown out of an intense desire to save the vaccination system from reproach and total failure, and the profession from chagrin at the gigantic swindle put upon it, and which it so greedily bit at. By the way, how many physicians can tell what the matter was with which Jenner performed his first vaccinations? Strange to say, though I have asked many, I have never received a correct answer. Suffice it to say just now, it was not with matter taken from the bovine race. This simple question will reveal a vast amount of ignorance on the vaccination subject.

W. B. CLARKE, M. D.

Indianapolis, Ind.

Anacardium—Clinical and Toxicological.—In a late issue of the MEDICAL CENTURY is an article on *Anacardium Orientale*, by Dr. H. C. Kusselman, of Midway, Kentucky, entitled "Involuntary Proving," and in that article he refers us to another in the January 1st issue, by Dr. E. S. Breyfogle. I have read them both carefully, as I am very much interested in the drug, for the following reason:

About one year ago a young man presented himself at my office for relief from a gnawing, sickening pain, that would appear in the stomach as soon as it was emptied of its contents, and would continue until something was eaten, which would at once dispel it, to appear again as soon as the food eaten had passed out of the stomach. And so, for relief, when the pain appeared, he would visit the cook and get a crust, to return again in about four hours for another bite. Thus he had performed for a week, and finally became convinced the machine was out of repair, and so "brought it to the shop to be fixed." He was apparently well in every other respect. I took a two-drachm vial and filled it with *Anacardium* and *Alcohol*, one to four drops to be taken every two hours. He wished to know if I thought it would help him. I told I thought it would and he went away happy.

About two days afterward he came back looking ten years older. I asked him what was up. He said he thought there was something else the matter, that he could not sleep last night on account of an intolerable burning—itching all over him and the more he scratched the worse it itched. I sympathized with him and soberly told him he would have to take down his pants and show me the field. When, ah, me! There was as fine a looking pair of thighs as we commonly see with a case of poison ivy, a rosy rash, with here and there a papular eruption (which later terminated in vesicals filled with a watery solution). This rash appeared on the chest and back, on the arms and scantily on the hands. It so much resembled poison ivy that I questioned him carefully if he had been near it, but he assured me that he had not been away from his business nor anywhere that he could be exposed to it. I at once concluded it was my harmless vial of medicine. I gave him some sugar pills to quiet his mind, and asked him to report next day, which he did with no improvement. I continued the treatment and the next day there was less rash and at the end of a week it had disappeared entirely, and, by the way, so had the stomach difficulty. This was a very interesting case to me. Since then I have prescribed *Anacardium* in a few

cases of poison ivy and I think with as good results as with any other remedy. The more I use it in this trouble the more I am convinced that it is oftener indicated in that trouble than any other remedy that we have.

A. W. Swift, M. D.

Belvidere, Ill.

Sanitary Science.

TO WHAT EXTENT DO PHYSICIANS CARRY INFECTION?

By F. H. ORME, M. D., Atlanta, Ga.

EX-PRESIDENT AMERICAN INSTITUTE OF HOMEOPATHY.
SANITARY SCIENCE SECTION AMERICAN INSTITUTE, DENVER, 1894.

With all the advancement in knowledge in general, and especially in medical knowledge, in recent times, there is still much that is unknown and mysterious concerning diseases, particularly infectious diseases; and, where there is lack of knowledge in matters of this kind, superstition rules and increases the fears that are natural to the situation.

While it is well understood by enlightened people that the dissemination of disease, like all things else in the universe, is governed by law, the laws governing the spread of infectious diseases have so far, to a large extent, eluded discovery, and the obscurity still attaching to the nature and cause of spread of pestilences is the source of an incalculable amount of dread and misery—for unseen and undiscoverable foes affright us more than do real dangers. Shadows produce paralyzing terror, while substantial enemies excite courage and arouse to resistance.

Is it not possible by a systematic study of the subject, with a determination to eliminate all possible sources of error, to separate the real from the imaginary dangers? Surely the subject is worthy of an effort, and might well engage the attention of the Sanitary Section and the sanitary experts of this Institute.

The question at the head of this paper of necessity opens up a wide field of research, involving the whole question of infection and disinfection, directly or collaterally: What is the infective principle? Under what conditions does it live, and by what is it destroyed? How is it conveyed, and how can its conveyance be prevented?

It would seem that these questions ought to be readily settled by a resort to the experience of the hundreds of thousands of physicians who have made observations. But alas! when we apply to this source for information we find wide differences of views, and are led to ask, why is this so? Certainly it is not that the laws in the cases are variable, but that cases are modified by interfering influences, and that physicians reason differently from the same appearance of facts. All theories, at least, appear to be overthrown by particular cases, while these, more carefully observed and analyzed, would sometimes be found to be confirmatory—exceptions proving the rule. A renewed attempt should be made to gather the results of experience, and to read aright, in the light of increased knowledge, their import.

The writer has for some time past taken considerable pains in this direction, and by direct personal application and by correspondence has obtained the observations and opinions of a large number of physicians of extended experience, the whole embracing in the aggregate many hundreds of years of practice; and the almost uniform testimony has been that they have never known of their conveying any of the infectious diseases from infected patients or houses to other houses. A few questionable exceptions have been given; but the consensus of opinion (corresponding with that of the writer) seems to be that diseases are not conveyed by physicians or visitors to such patients, as is generally supposed, certainly not to the extent that is generally apprehended.

If the infection of the most common of the infectious diseases, such as small-pox, scarlet fever, diphtheria, measles, chicken-pox, etc., were conveyed as is generally thought, physicians in active practice could often be tracked through the cities by the houses infected by them; and the children of these physicians would show a much larger proportion of cases of these diseases than is found in the families of others, which is not, so far as can be learned, the case. These two considerations seem to have much significance, and much force as argument against the popular opinions.

One physician of eminence, whose practice, large in extent, has included forty-eight years, recently assured the writer that in an attendance upon about one hundred cases of small-pox, while also engaged in general practice, he never took any precautions whatever but sat upon the beds of the patients and handled them without reserve, and yet he never knew a case in which he was responsible for the spread of the disease. Much similar testimony concerning this and other diseases, has been gathered, which corresponds, in a general way, with that of the writer.

Further: It has always been the practice of the writer as of many others, to direct that, after a case of scarlet fever, or other infectious disease, when the period of danger of infection from the person is considered passed, the bedding and other articles about the rooms of the pateints should be exposed freely to the sun and air,—generally on the lots on which the houses stood,—while a case of infection from this practice has not been heard of, nor can any be recalled. Now, if the diseases in question were disseminated as is generally supposed, why should not whole communities be infected from such practice?

It is somewhat the custom with some physicians to have bedding, clothing, carpets and other articles in the room of infected patients burnt, or fumigated, or "disinfected," as is considered,—without knowing, to be sure, whether these proceedings, excepting the burning, really disinfect or not. To be truly consistent on this line, the houses should be burnt down.

An interesting incidental question here arises: To what extent do "disinfectants" disinfect? During the yellow fever epidemic in New Orleans in 1878, that distinguished sanitarian, Dr. White, conceived the idea that he could demonstrate the disinfecting quality of carbolic acid and check the spread of the epidemic, and had the priviledge of, and facilities for disinfecting a selected district of the city. The whole air of this district was made redolent—offensively so—was really saturated with the disagreeable so-called disinfectant, but, behold! the pestilence marched right on, without any regard to this obnoxious "protection." Might not a scientific test prove the inefficacy of many other supposed disinfectants? Our germicides appear to be only effective against *discovered* germs, while the still mysterious causes of disease defy this power.

Manifestly there are erroneous views held by at least some of the profession and the people, and it is obviously desirable that something more positive should be known about the conditions under which the germs of different diseases live and are propagated,

and under which they die, or have their development retarded.

All diseases are not subject to the same laws of propagation or conveyance; but there are some rules that appear to be pretty general. It may be safely stated, for example, that Nature's disinfectants, *fresh air, sunlight and hot water*, are the chief safeguards against infection, and are of more worth than all of the chemical disinfectants (valuable as these are) that were ever discovered or turned out from a laboratory. It is because of these that infectious diseases die out; it is because of these that the bedding of patients suffering from the most virulent infections, when hung out in the air and sunshine, do not spread diseases; for it is well known that among the poorer classes of people infectious diseases often exist and then die out, sometimes without having been carefully diagnosed, and often in the absence of any sanitary precautions.

The danger of continuing and spreading these diseases probably lies, in a great measure, in *confined air and darkness*. Thus it is that a doll, or other article once handled or worn by an infected patient and then packed away, will, when brought out, cause a reappearance of the disease often after a long interval of time. Thus it is that articles of clothing and other things from an infected chamber, when packed and sent abroad, may carry the seeds of diseases; for the likelihood is that in the *darkness and confined air* of a trunk, box, or package, will be found the conditions favorable to a multiplication of the spores (on the cryptogamic theory of Prof. J. K. Mitchell) or germs of diseases. Often has it been found that the persons first opening such a box at a point distant from that from which it was sent, has become a victim of infection, and sometimes from such a box, an epidemic has spread.

Clothes-presses, closets, trunks and closed places generally, are to be regarded with suspicion, while it is doubtful if the free air through which the sunlight beams, in a room or out of doors, will support the life of the spore, or germ, or influence, whatever it may be, that is the specific cause of an infectious disease.

While great care should always be exercised, especially in attendance upon obstetrical cases, there has evidently been an unnecessary amount of apprehension felt with regard to these matters; and it is with the hope of stimulating direct investigation with a view to discovering the exact amount of precaution required in given cases, that this article, which is chiefly suggestive, has been penned. That much inconvenience might be avoided, and much fear and anguish of mind allayed by better knowledge of these subjects is unquestionable; and it is truly lamentable to think of the waste there has been of time and money and effort in perfectly useless measures. Who will make the investigations that will result in some positive knowledge? Who will prove to us the absolute utility of something better than *sunlight, free ventilation, soap and hot water*, as preventives of infectious diseases generally, or than *frost* for yellow fever?

As matters now stand, it seems evident that physicians, nurses and others, visiting infected patients, do not convey the infection, unless by carrying some closed package away with them; or, if so, to a trifling extent and under exceptional circumstances. A handkerchief taken out in an infected room, and then thrust into a dark, close pocket, may be more dangerous than all of the apparel exposed to the air, and may have been the cause of some rare cases of conveyance by physicians.

It seems evident, also, that the most common infections do not migrate upon the wings of the wind, or live upon exposed clothing, but are rather destroyed by exposure to open air. Whooping-cough may be an exception (and there may be others, as yellow fever in epidemic seasons), for we find this occurring under circumstances which would seem to disprove infection in the usual way; but the subject needs careful revision, and it is to be hoped that we may before long have some definite knowledge of the nature of infections, and the laws governing their diffusion. May our Institute not be the leader in the investigation of this important subject?

One more thought in this connection: The Homeopathic Yellow Fever Commission that met in New Orleans in 1878, in its report to Congress, recommended, among other sanitary measures, *the cremation of filth*. What more efficient measure of prevention of infection can be suggested than the destruction of fomites, as they are found in filth, in refuse? How many times has infection of one sort or another been concealed and carried over from one place, or from one season to another, by valueless rubbish that should have been destroyed long before, instead of being buried to be resurrected?

One step further should the earnest professional sanitarian go: "Out upon that great depository and preserver—that pestiferous perpetuator of infection, the grave-yard! Up with that greatest of sanitary institutions, *the crematory!*" should be the cry of every brave sanitarian. *The great need throughout our nation—in the way of sanitation—is a system of cremation.*

Psychology.

A PSYCHOLOGICAL STUDY.

By N. O. PENNOYER, M. D., Kenosha, Wisconsin.

physician and surgeon to kenosha sanitarium.

With the increased interest in hypnotism and allied phenomena, both in this country and in Europe, I am tempted to briefly report a study in mental states which to my mind is quite unique. It was in the first year of my medical practice, twenty-four years ago, that a patient, Mrs. X——, a lady thirty-five years old, came to the institution of which the present sanitarium is an outgrowth for treatment. The family history was good; both the father and mother being strong and healthy, as well as a brother older than the patient, whose health record was of the best. A younger child, however, was not so favored. The parents, sturdy country people as they were, in the season previous to the birth of the daughter were engaged in building a new home. In times sixty years ago help was scarce, particularly domestic, and to the mother of the expected child fell not only the ordinary duties of a farmer's wife but the men engaged in the building of the house were boarded and cared for on the premises. To say that the woman was over-worked faintly expresses it. With body and mind and nerves strained to the utmost for months, a babe "worked to death" before birth, was brought into the world. While perfectly formed physically there were unusual restlessness, nervousness, and sleeplessness in the child. When but a few years old somnambulism to a very marked degree developed, which later exhibited trance-like states, in which the girl, being unusually precocious and bright, would, in her sleep, preach sermons, selecting her text from the Bible and expounding therefrom to the wonder of the family and the neighbors

who came in to hear such extraordinary exhibitions of wisdom and learning in one so young and under such unusual conditions.

Passing puberty a train of hysterical symptoms developed, there being at times spasms and again contractures of the extremities which remained for months. During all these years the somnambulism prevailed, and whenever it was possible for the girl to use her hands it was unsafe to leave articles of clothing or pieces of cloth within reach, as they would be "worked up" in the night into garments not intended or suited for future use in the family. Passing rapidly from this period of her life to the time she came under my observation, merely mentioning that she was married when about twenty-two years old to a physician who tenderly cared for her during her life. While physically incapacitated, most of the time, to either enjoy or do what came in the way of most women, the life of the lady was one of remarkable benefit to those coming in contact with her, and to her husband a helpmate of extraordinary ability. It is needless to say the patient being born exhausted, possessing a brain almost ceaselessly active, always alive to the interests of her household, which was a large one, her husband's work being similar to my own, that she left her home for a needed rest. Hers was a case which I have included under the head of "true hysteria," one of the strong-willed, active souls, whose courage and ambition far exceeds their strength, the inevitable result being collapse and loss of control of the nervous system, even to perverted action of the sympathetic system with all the varying symptoms which such a condition implies.

I shall not attempt to give a consecutive narrative of the case, nor a sequence of the mental phenomena as they occurred. I will only state that my observation extended over the period of several years, the patient being under my charge at intervals of a few weeks to months, the longest time being nearly a year. I soon discovered that the patient was exceedingly sensitive to mental influences; that she was susceptible to what is termed "animal magnetism," the brain being quieted and nervous symptoms being controlled under favorable conditions. More than this: with gentle pressure on the ball of the thumb, when the brain was sufficiently quieted, she would go into a clairvoyant state, in which condition she would remain quiet, apparently passing into normal sleep at times if not talked to or disturbed in any way. After a time, if not wakened from the trance, she would ask to be brought out of it. At her suggestion, in this state I always wakened her by pinching the skin of one of her fingers. This method shocked her less than any other.

Discovering that my patient was endowed with the sixth sense I put the faculty to test upon some of the things I knew and upon some that I did not know. An example or two of the latter, displaying the prevision of the patient in an unmistakable manner, I may be permitted to relate.

Case 1.—In a room remote from our patient was a young lady who was suffering with sciatica, which had persisted since a fall from a carriage some years before. Being thrown quite violently she had struck upon the thigh, which was afterwards affected. This pain was so severe and intractable that the opium habit was induced, the thigh showing marks of a long succession of hypodermatic medication. This case had been under the care of my preceptor the year before, having been somewhat improved by the hygienic and hydropathic treatment then employed. Returning home she soon relapsed into the old condition, her sufferings being worse if anything than ever before. Besides the sciatica she had attacks of gastralgia as severe as any I have ever witnessed. In one of the earlier trance states of patient No. 1 I asked an opinion of case No. 2. To my surprise she told me that the cause of the sciatica was a retroverted uterus. An examination revealed the correctness of the diagnosis.

Case 2.—During these days there came into my hands from those of an old school practitioner an old lady somewhat decrepit with rheumatism, who injured an ankle sometime before. Previous to my being called to the case a splint had been taken off the injured member, the case having been treated for fracture of the fibula. Her foot was displaced outwardly so much as to prevent the patient putting any weight on that extremity. In these days of conservative Homeopathic surgery I suggested a brace for the deformity. Accordingly I moulded a paste board to the new turn of the ankle, took some measurements and forwarded them to an instrument maker, with an order to make the support. Meanwhile I treated "the case," giving *Causticum*. When the brace arrived I discovered that a serious mistake had been made, the instrument being adapted for the opposite deformity of the foot. While waiting for the correction of the error by the instrument maker at one of the sittings with my clairvoyant I asked for light on the case. To my surprise she very decidedly told me that the present deformity was not caused by a fracture but by a contracture of the ligaments resulting from rheumatism.

Briefly stated: When at last the brace came "to foot" the deformity had disappeared. The old lady could walk fairly well. The brace was consigned to the attic.

Now for conditions: The clairvoyant was confined to her room and bed. Never saw either of the cases and had no way of communicating in any manner with them. Neither did she read my mind, for the conclusions arrived at were diametrically opposed to my line of thought in both cases. There were many other tests made during the months following, but the cases above cited are enough to indicate the existence of a mental state heretofore doubted by many neurologists and scientists.

At another period an entirely different experience was noted. Instead of being confined to her bed the patient was able to be up and move about her room a little. Then a somnambulistic condition of extraordinary degree was manifest. I first noticed that the patient was sensibly annoyed at the absence of certain toilet articles, or dress, which she was accustomed to use. Upon inquiry I learned that her trunk was locked and the key misplaced or hidden, so that days passed with the patient thus inconvenienced. In her waking state she was unable to give any information regarding it; in the somnambulistic state she utterly refused to tell me where the key was to be found, although I argued the case with her, telling of her "day necessities" and the annoyance to which she was subjected. To my appeals she said that the trunk was locked purposely so that I could not get at her possessions. Later, with a little tact, I would be able to quiet her, throw her into clairvoyance, when I would secure the key and unravel any other snarls her eccentricity had occasioned.

While erratic in many ways in the somnambulistic state there were many things which she would do as well as in the waking state. At one period the habit

seemed quite intractable, there being weeks together in which at about the same time in the evening it would come to remain until I could bring her out of it. For a time, from Sunday night until Monday night, the spell would not be broken, the condition lasting from twenty-six to twenty-eight hours. On Monday of each week she would in this state attend to routine duties such as sending her linen to the laundry and similar domestic matters. She would even go about the house to rooms on the same floor and visit with other patients and do all ordinary things in apparently regular order. Waking in her normal condition on Tuesday morning, she would ask the nurse to attend to matters pertaining to the day before. When told that they had already been executed, she would then become cognizant of the condition which obtained the previous day. I will mention here that she was totally oblivious of all her actions in the somnambulistic state; her relations to time stopped as completely as if she were suffering concussion or compression of the brain.

To explain the regular Monday lapse, much personal attention was required each evening having to lessen the cerebral congestion sufficiently to transfer the somnambulistic to the clairvoyant state, and for a time no other method would bring her back to her normal state. Unlike most physicians in their work I took a night off, Sunday being the time for rest. The somnambulism coming on Sunday night would continue until I was able to break it Monday. How much longer it would have continued I cannot say; possibly for weeks had her brain been able to stand it, which is doubtful. I will offer a suggestion here, that persons, not epileptics, who lapse into an unconscious state and wander away from home for weeks, are probably somnambulists.

In my case while there was total loss of memory, not even consciousness of a dream, there was not any rest to the nervous system which comes with sleep. There could have been no greater exhaustion had she been forcibly kept awake for a corresponding time. Some of the physical features connected with the somnambulistic state are interesting. At eight o'clock in the evening sitting at the patient's bedside and engaging her in conversation, the face and eyes indicated fatigue to a marked degree. In a few minutes, perhaps in the middle of a sentence, while speaking, the voice would become a little less distinct; then the head and eyes would droop like that observed in the person who goes to sleep in church. Next within a few seconds the carotids would visibly fill and throb, the face become suffused with blood and the next instant she would open her eyes wider if anything, in somnambulism.

Under these circumstances there would be little difference observable between the two states, only that the mental processes seemed more active than before. In this condition she was more sensitive to light and usually desired the lamp turned down a little. When left to herself she would soon cast about for something to occupy her hands and mind. Occasionally she wrote; again, if able, would go out on the veranda for a while, or not being able to leave her bed she would attempt some sewing. Indeed, sewing seemed her "particular vanity;" she would rip up some article of clothing, like a nightdress, cut it down to other proportions and then make it over. Once while working on a garment she desired a few yards of trimming or edging to complete it.

About this time she became a little piqued or manifested some antipathy for me, for some fancied reason, and expressed a desire to see in my place another physician, who lived in town and whose name she had heard. I withdrew telling her before I went that I would comply with her request. In the course of half an hour I returned, tapped on the door, entered and introduced myself as Doctor A., when she appeared glad to see me. As Doctor A. I became interested in her work and soon she commissioned the new doctor to buy the trimming desired. As Doctor A. I returned night after night having no trouble to quiet her, nor did she question my new cognomen. The light was always well shaded but her powers of observation and reasoning in this state were not up to normal. Once she remarked that I looked very much like Dr. Pennoyer, when I told her, truthfully, that I was often taken for him.

To return to the clairvoyant state: While the patient would go into "trance," as before mentioned, there were times when her prevision was nearly as remarkable in every day mental clothes as in "trance." In passing let me explain that the three states of mind were distinct. There were first, the normal, in which she lived; the somnambulistic, of which she was never conscious, memory of this latter never even dawning upon her natural self; the clairvoyant, in which she knew all pertaining to both of the other states, beside superadded a gift of the "All-knowledge," the limits of which in this case I shall never know. At one time I asked how or in what manner she could see conditions of the body and give a diagnosis as in examples mentioned. She said that instead of the body being opaque to her it was transparent, that she could see, for instance, the contents of the stomach as well as if the walls were made of glass; moreover, acts of the individual and conditions leading up to a certain observation were plainly arrayed before her mental vision. This was a source of annoyance to her when this power occurred in the normal state, as for example, when the fat boy who brought wood to her room had stored away in his capacious maw the whole of a stolen pie in addition to the ample dinner already devoured. The extraordinary talents of the lady were always a source of mortification to her; she regretted her ability and her disabilities and was quite unlike the much advertised seventh daughter of the seventh son, the latter comparable to Bret Harte's character "which for ways that are dark and tricks that are vain the heathen Chinee is peculiar."

Beside the phenomena already described there were other mental conditions in this case with which we meet in every-day practice. When the cerebral congestion was severe there were hallucinations in variety. She frequently imagined she had been out driving, even naming the persons accompanying her, when in fact she had not been out of bed. She frequently had the shocks in her head described by Searle in his essay, "A new form of nervous disease." These shocks were so severe, and as real a sensation of pain as from a blow attended them, that often the patient would charge me with having struck her on the head. The tact required to manage such a bundle of nerves was an experience in itself. The will seemed to pull in different directions. Many a time did she determine to go home, pack her trunk, even put on her cloak and hat ready to start while under nervous tension caused by cerebral congestion. Afterwards when in clairvoyance she would tell me that I must not let her go and would suggest the means most suitable to quiet the excitement. She would then explain the causes of aggravation of her symptoms, which I would verify upon inquiry in

her normal state. The patient's judgment in every matter submitted to her in the mesmeric state was always good; no matter how erratic her fancies or how stubborn the will in either of the other conditions, whatever she said or did in the prescient state seemed attuned to the divine will. Aside from the extraordinary experience of which the above is but an outline I learned from the study and management of this case how essential it is not only to keep perfect self-control at all times, but how important it is when assuming the care of a highly wrought, delicate, nervous organization, always to go to them in an unperturbed state of mind. More is needed than the semblance of composure. Back of a quiet manner there must be an unruffled spirit, a calm undercurrent of good temper and a living spring of hope. "As in water face answereth to face, so the heart of man to man."

Medical Legislation.

DISTRICT OF COLUMBIA MEDICAL BILL.

53d CONGRESS, 2d Session, H. R. 7661.

In the House of Representatives, July 7, 1894.

Referred to the Committee on the District of Columbia and ordered to be printed.

Mr. McMillan (by request) introduced the following bill:

A BILL

To regulate the practice of medicine and surgery and to license physicians and surgeons in the District of Columbia, and for other purposes.

Whereas because of the absence of a law to ascertain the qualification of individuals desiring to practice medicine and surgery in the District of Columbia it is made a resort of persons who are excluded from the practice of medicine and surgery in other States by laws in said States requiring evidence of such qualifications: Therefore,

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Commissioners of the District of Columbia shall appoint a board of examiners which shall be known as the Board of Medical Examiners of the District of Columbia; said board shall consist of nine members, five members to be selected from a list of not less than ten names submitted by a majority vote at some regular meeting of the Medical Society of the District of Columbia, three members to be selected from a list of not less than six names submitted by a majority vote at some regular meeting of the Washington Homeopathic Medical Society, and one member to be selected from a list of not less than two names submitted by a majority vote at some regular meeting of the Eclectic Medical Society of the District of Columbia. Of the members of the board first appointed three shall be appointed for one year, three shall be appointed for two years, and three shall be appointed for three years, and thereafter each member of said board shall be appointed for a term of three years, or until his successor is appointed: *Provided,* That no member of said board shall serve more than two terms in succession, and that no member of said board shall have been engaged in the practice of medicine and surgery in the District of Columbia for less than ten years at the time of his appointment: *And provided further,* That the Commissioners of the District of Columbia may at any time remove any member of said board, upon petition by the medical society by which such member was first nominated, and that in the case of the death, resignation, or removal of any member, the vacancy for the unexpired term of said member shall be filled in the same manner as other appointments are made.

Sec. 2. That each member of said board of medical examiners of the District of Columbia shall, before entering upon the discharge of his duties, take an oath to administer fairly and impartially the provisions of this Act; said board shall elect a president, a vice-president, a secretary, and a treasurer; it shall have a common seal, and the secretary shall be empowered to administer oaths in taking testimony upon any matter pertaining to the duties of said board; said board shall hold meetings for examination in the city of Washington on the second Thursday in January, April, July, and October of each year and continuing so long as may be necessary to examine all applicants, and at such other times as a majority of the board may deem expedient; said board shall keep an official record of all its meetings, also an official register of all applicants for examination for a license to practice medicine and surgery in the District of Columbia; said register shall show the name, age, and place, and duration of residence of each candidate, the time he or she has spent in medical study, in or out of medical school, and the names and locations of all medical schools which have granted said applicant any degree or certificate of attendance upon lectures in medicine, and shall show the shool of medicine which the applicant desires to practice; said register shall also show whether such applicant was rejected or licensed under this Act; said register shall be *prima facie* evidence of all matters contained therein. It shall be the duty of the secretary of said board to mail to the address of each applicant a notice of the time and place of examination; said notice shall be mailed not less than seven days before the examination, and at a longer period, if requested by the applicant at the time of making application; said board shall make such rules and regulations as they may deem necessary to carry into effect the provisions of this Act; said rules and regulations, when approved by the Commissioners of the District of Columbia, shall have full force and effect of law: *Provided,* That said board may elect a secretary from other than its own members, and when so elected said secretary may be removed at any time by a majority vote of said board.

Sec. 3. That from and after the passage of this Act all persons desiring to practice medicine and surgery in any of their branches in the District of Columbia shall apply to the said board of medical examiners for a license so to do; applicants shall submit to examination upon the following-named branches, to wit: anatomy, physiology, chemistry, pathology, materia medica and therapeutics, hygiene, histology, practice of medicine, surgery, obstetrics and gynecology, diseases of the eye and ear, medical jurisprudence, and such other branches as the board may deem advisable; said board shall not examine any applicant until satisfactory proof is furnished that he is of good moral character and over twenty-one years of age, nor until he has presented a diploma conferring upon him the degree of doctor of medicine, issued by some medical college authorized by law to confer such degree. *Provided,* That said diploma, if issued prior to July first, eighteen hundred and ninety-seven, shall be accompanied by satisfac-

tory evidence that said applicant has studied medicine and surgery for not less than three years prior to the issue thereof, and if issued subsequent to June thirtieth, eighteen hundred and ninety-seven, shall be accompanied by satisfactory evidence that the applicant has studied medicine and surgery for not less than four years prior to the issue of said diploma. All examinations shall be both theoretical and practical, and of sufficient severity to test a candidate's fitness to practice medicine and surgery.

Sec. 4. That each application for a license shall be made to the secretary of said board of medical examiners upon a form prescribed by said board and approved by the Commissioners of the District of Columbia, and shall be accompanied by a fee of twenty dollars. Each application shall be in the hands of the secretary of said board not less than two weeks before the day set for examination. Each application shall state the full name and address of each applicant, his or her age, the place and duration of residence of said applicant, the time he or she has spent in the study and practice of medicine in or out of medical schools and hospitals, the names and locations of all medical schools which have granted said applicant any degree or certificate of attendance upon lectures in medicine and surgery, the school of medicine which the applicant desires to practice, and such other information as the board may require; said information shall be furnished under oath. Any application may be rejected for refusal to furnish any of the information called for or for other irregularity. Each application shall be kept on file by the secretary of the board.

Sec. 5. That examinations shall be oral and in writing: In all examinations the questions must be, except in practice of medicine and in Materia Medica and therapeutics, such as should be answered in common by all schools of practice; and if the applicant intends to practice Homeopathy or Eclecticism, the member or members of said board of the schools selected by him shall examine said applicant in practice of medicine and in materia medica and therapeutics. The votes of all examiners shall be "yes" or "no" for the respective branches, and written with their signatures, upon the backs of the examination papers of each candidate; said examination papers shall be kept on file by the secretary of said board for five years, and shall be *prima facie* evidence of all matters contained therein.

Sec. 6. That if any applicant shall pass such examination as is hereinbefore provided for in a manner satisfactory to seven members of said board of medical examiners of the District of Columbia said board shall issue a license, signed by the president and the secretary thereof and attested by its seal, which shall entitle said applicant, after it has been registered as hereinafter provided, to practice medicine and surgery in the District of Columbia: *Provided*, that a license shall be issued without examination to each physician a graduate of any medical college in good standing who is registered at the health office at the time of the passage of this Act. All licenses issued by said board shall be numbered consecutively, and a register shall be kept by the secretary showing the number of each license, the date of issue and to whom issued.

Sec. 7. That the board of medical examiners of the District of Columbia may by a vote of seven members refuse to grant or may revoke a license, or may cause the name of any person to be removed from the record of the supreme court of the District of Columbia and from the register of the health office, for the following causes, to wit: Chronic and persistent inebriety, the practice of criminal abortion, conviction of crime involving moral turpitude, or for publicly advertising ability to treat or cure diseases. In complaints under this section the accused shall be furnished with a copy of the complaint and be given a hearing before said board in person or by attorney. Said board may at any time within two years from the refusal or revocation of a license or the cancellation of registration under this section, by a unanimous vote, issue, without examination, a new license to the physician so affected restoring to him all the rights and privileges of other physicians licensed under this Act.

Sec. 8. That any person receiving a license as hereinbefore provided, shall have it recorded in the office of the clerk of the supreme court of the District of Columbia within three months from the date of said license, and the date of record shall be indorsed thereon by said clerk; and the holder of the license shall pay to the recording clerk a fee of fifty cents for making the record. The holder of said license shall, after the same has been recorded, exhibit the same at the health office, and register, in a book provided for that purpose, his name and address. Whenever a license is revoked by said board the secretary thereof shall report that fact in writing to the clerk of record and to the health officer of the District of Columbia, who shall thereupon cancel such registration.

Sec. 9. That this Act shall not apply to commissioned surgeons of the United States Army, Navy, or Marine-Hospital Service, nor to regularly licensed physicians and surgeons in actual consultation from other States or Territories; nor to regularly licensed physicians and surgeons actually called from other States or Territories to attend specified cases in the District of Columbia; nor to physicians graduates of Medical Colleges in good standing already on the register at the health office, who shall be required, without examination, to register their names with the supreme court of the District of Columbia and at the health office, and shall in all other respects be subject to the rules and restrictions of this Act; nor to dentists in the legitimate exercise of their profession; not to midwives, registered at the health office of the said District, in the management of uncomplicated cases of obstetrics; nor to the treatment of any case of actual emergency; nor to the use or ordinary domestic remedies without any fee, gift, or consideration of any kind being given in return therefor.

Sec. 10. That any person shall be regarded as practicing medicine and surgery within the meaning of this act who shall append the letters M. D. or M. B. to his or her name, or who shall prescribe, advise, or apply, for the use of any person or persons, any drug or medicine or other agency, or who shall perform any operation for the treatment, cure or relief of any bodily injury, infirmity, or disease, or who shall publicly profess to do any of these things.

Sec. 11. That from and after the passage of this act any person practicing medicine and surgery in the District of Columbia without having first obtained a license to so do and registered the same as herein provided or in violation of any of the provisions of this Act, or any of the rules and regulations made by authority conferred by section two thereof, or after his license, or registration, or both, has been canceled by order of the board of medical examiners of the District of Columbia, shall be deemed guilty of a misdemeanor, and, upon conviction thereof,

shall be punished for each offense by a fine of not less than fifty nor more than five hundred dollars, or by imprisonment in the District jail for a period of not less than ten nor more than ninety days, or by both such fine and imprisonment. It shall be the duty of the United States district attorney for the District of Columbia to prosecute all violations of the provisions of this Act.

Sec. 12. That the secretary of the board of examiners shall be paid for taking testimony the same fee that is allowed to an examiner in chancery for the same service. The expense of the said board and of the examinations shall be paid from the license fees herein provided for, and if any surplus remain on the thirtieth day of June of each year the same may be divided among the members of said board, pro rata to the number of examinations at which they have been present during the preceding year.

Sec. 13. That all Acts or parts of Acts, general or special, now existing not in accordance with the provisions of this Act, or inconsistent therewith, be, and are hereby, repealed.

Correspondence.

PASSIFLORA FOR SLEEPLESSNESS.

Abilene, Kans., July 16, 1894.

Editor Medical Century:

In the report of third session of Materia Medica Section, Denver meeting American Institute of Homeopathy, I am made to say I "have given tincture of *Passiflora incarnata* in doses of one hundred and ninety drops," which is an error. I stated that I had used it with benefit in insomnia in doses of thirty drops, repeated in half an hour, when necessary; that I had once taken it myself as above, and being wakened several times during the night had taken one hundred and ninety drops between 10 p. m. and 4:30 a. m., without noticing any unpleasant effect whatever. I will add that it required two doses to get asleep each time, and a repetition of them whenever I wakened.

However, on subsequent nights the repetition was not necessary, a smaller quantity being required rather than a larger, as with many drugs. The susceptibility to its action varies greatly in different persons, a few adults being helped to sleep by five drop doses, while with others thirty drops have very little effect. With most, however, that dose will at least exert a soothing, if not a soporous influence.

F. J. Boutin, M. D.

LETTER FROM DR. JUMP.

LYCOPUS FOR EX-OPHTHALMIC GOITRE—DIFFICULT CASES FOR CONSULTATION—MEDICAL CENTURY FRONTISPIECES.

Oberlin, O., August 14, 1894.

Editor Medical Century,

Your magazine is always welcome, and I think it improves from month to month.

Would it not be well to have a little space where puzzled doctors could state difficult cases and ask advice from the Century readers?

I sometimes have a case upon which I should like to have the opinions of the Homeopathic physicians through the country. Rare cases would thus be brought before us for study.

I have noticed two or three articles in the Medical Century on ex-ophthalmic goitre with a suggestion of remedies. In a recent case resulting from severe affliction I gave *Lycopus*, 6x, which cured.

The plates are a great addition to your valuable journal. The pictures are indeed speaking likenesses and, framed, will appropriately adorn the office of a physician. We are all proud of the physicians and surgeons, as well as editors, in the Homeopathic school who have made their mark in the world. I am saving my plates for framing. I shall welcome the day when the Medical Century becomes a weekly magazine.

Respectfully yours,

Julia Chapin Jump, M. D.

[Dr. Jump's suggestion of a difficult case department is an excellent one and already exists in the "Medical Century Clinic." Send along your difficult cases for advice and consultation.—Ed.]

AN APPRECIATIVE LETTER FROM FRANCE.

Editor Medical Century:

Enclosed find postal order for $3.50 in payment of my subscription to the Medical Century for 1894.

I take advantage of this occasion to congratulate you upon the excellent course in which you have started and successfully carried your journal. Through it you have rendered a very interesting and substantial aid to the Homeopathic cause. Materials of real usefulness to the physician are accumulating year by year in the Century, and soon it will become of itself an indispensable medical library.

And now, having congratulated you upon your intelligent and fruitful work, permit me to congratulate myself in being one of the number of your readers, and accept, my honored brother, this testimony of my respectful and devoted sentiment.

Dr. Brieu.

Toulon, France, 96 Boul. de Strasbourg.

Dr. Senn, Chicago's most noted surgeon, has just issued a neatly illustrated reprint from the St. Louis *Clinique* on Abdominal Surgery on the Battlefield. Like all of Dr. Senn's articles it is scientific, accurate and practical. The illustrations are neat and lend much of interest to the paper.

A Typhoid Fever Number of the Medical Century is in prospect. Contributions on this disease, in its every aspect and bearing, have already been solicited from a large number of our more prominent practitioners and teachers over the country for the issue of October 1st, and it is our intention if enough copy is received to make that number an exclusively typhoid fever issue. The subject has been divided into sections and it is expected that we will be able to present papers on the etiology, pathology, clinical course, hygiene, diet, nursing and medical treatment and general management of the disease from men who are competent to speak and write upon it. Coming at this season of the year it is believed this number will possess unusual value and interest to the readers of this journal. In proper season special numbers on other important diseases will be issued. It is the intention to make the Medical Century more practical and helpful to the practitioner and student than it has heretofore been, even though it has not been altogether valueless in these respects in the past. Look out for the typhoid fever number.

Medical Century

An International Journal of Homeopathic Medicine and Surgery.

C. E. FISHER, M. D., - Editor,

ASSOCIATE EDITOR:

W. A. DEWEY, M. D., New York.

Chicago, September 1, 1894.

BLESSED CALIFORNIA AND ITS LESSON.

What a blessed country California must be, practically exempt as it is said to be from the summer complaints of children! What a boon to young mothers that glorious climate of the golden shores of the Pacific! No summer complaints; no diarrheas of teething infants; no sleepless nights and tired nerves, and distracted parents, and worn out doctors, and exhausted nurses, and Dr. Kraft's grandmothers to give the sick infant yarb teas, and dog's milk, and flour balls, and sugar teats, just to keep it quiet you know! What a blessed country that must be, indeed. One of the banes of our medical life has been the summer diarrheal disorders of nursing and bottle-fed babies. While perhaps not so prevalent in more recent years yet the time has been when summer complaints carried off the little ones by the hundreds and nothing but dread diphtheria has risen before us so much a nightmare as cholera infantum. Whether a resident of the north, the south or the west we have met with about the same experience and have come to shrink from contact with the bottle-fed baby in summer time. And just to think that there is a land that does not suffer from the ravages of cholera infantum and allied disorders!

Dr. Boericke's testimony is valuable from more than one standpoint. Not only does the information he imparts suggest a climate for our little people who have suffered acute attacks of cholera infantum and who are slow in recovering from it, but he gives us hope for parents who have suffered the loss of one or more little ones from this disorder and who know not which way to turn lest they may lose others, perhaps yet unborn, going childless through life. He also supports right strongly the position of Dr. Mayer, in the Century of August 15, our special cholera infantum number, that the open air climate, the out of door life of New Orleans is the off-set to its filthiness, preventing vast epidemics of summer complaint. Dr. Wm. Simpson, of San Jose, enters into particulars more than did Dr. Boericke, but his contribution came too late for our special number. It will be given with other papers on this subject in the issue of this journal bearing date of September 15. In it he clearly argues that 'tis the out door life and the freedom from hot nights and consequent nerve prostrations that give to California immunity from diarrheal disorders of infants, and thus the testimony of Drs. Mayer, Boericke and Simpson possesses value to us and gives us hints which we cannot well overlook.

Prof. Vaughan, of Ann Arbor, in the American Text Book on the Diseases of Children, holds that cholera infantum is strictly a milk infection and that where babies are bottle-fed there is infection of the food beyond peradventure. True, he is not able to give us the special bacteria that causes or is argued to cause this disorder, but he doesn't hesitate to brand the ailment as milk poisoning in every instance. It seems to us that this is strong grounds and that it is not supported altogether by fact. For instance; as physician for some years to the Protestant Orphans' Home, San Antonio, a southern city, where an out door life is possible well nigh the year round, we occasionally met with, in our hottest days, a case of cholera infantum in bottle-fed babies and also in others fed on breast milk, either that of the mother or a wet nurse. In more than one instance a child would develop summer complaint in very hot weather, especially if it should be sultry as well, while others being fed on exactly the same food, perhaps from the same breast or from the same bottle of artificial food, would develop no trouble at all. In occasional instances in private practice we have known the same experience to obtain, and more than once have lost a twin from summer complaint, its little fellow surviving or not being attacked at all though fed on exactly the same food. The California experience goes to justify the statement that milk infection is not necessarily the cause of this disease, and that it may not have aught to do with it in many cases. For the babies of California are fed on milk, and as many of them are human babies, they are fed on human milk, too. And then there is a certain amount of ignorance and poverty in the larger cities of the slope and many babies are bottle-fed and reared on artificial food. Of course we all know that there are other factors than climatic heat that cause prepared foods to spoil, and we see no reason why California babies, if artificially fed, should not suffer milk or food infection as well as Eastern babies. But let us suppose that they do not and that milk and artificial foods do not spoil in California, how do we account for the fact that the little ones of New Orleans are not poisoned unto death by milk infection. They have the heat down there sufficient to spoil thousands of gallons of breast and cows' milk and thousands upon thousands of pounds of prepared foods, and yet the babies are not the great sufferers they are in northern and middle

states. Nor is it likely that the out door life that these babies and California's babies lead enables them to resist the invasion of bacterial poisons to that extent that would afford practical immunity. If the germ theory of Vaughan and others held as universally as they would have us believe the climatic influences under consideration would not be so generally protective and so generally curative in diseases caused by germ infection, even though these might have some effect toward staying the ravages of the germ.

No, to our mind summer complaints are more largely due to physical conditions than to acute specific infection. We have seen babies thriving nicely, without serious evidences of trouble arising from their food, fairly prostrate out of existence during the prevalence of an unsually hot wave, more times than one. We have known this to be true in the case of twins where one child would suffer practically no inconvenience while its little fellow would go down almost as the dew melts before the summer sun. And, again, we have known instances wherein a mother would lose her baby during a term of hot weather from acute summer complaint and to save the breasts would nurse other children with perfect safety to them. We have also known instances wherein children fed on cow's milk would not fare alike, some giving way before physical conditions, others thriving on the milk the sick ones were taking. But these instances may be few in proportion to the number of children dying from cholera infantum and they have not been put forth as strong argument against the theory of milk infection. But the testimony of California and New Orleans, especially the testimony of the Southern city, affords an unusually strong argument, to our mind, and when this is supported by a good number of cases bearing the same testimony it is not altogether presumptuous to call the position of Vaughan into question. Is cholera infantum acute milk infection or is it superinduced largely by prostration of the sympathetic nerve centers from heat, the physical strain of the teething process and the natural sympathetic nerve involvement incident to ordinary disturbances of the gastro-intestinal tract? If milk is poisoned, if toxicogenic ptomaines develop in it or other artificial food, cholera infantum would very likely be the natural result. But is it not probable that this is not a common but an uncommon cause and that the great epidemics of summer complaint that occasionally sweep over the country are due more to atmospheric and physical causes than to the ptomaines of milk or other food.

An additional testimonial in this direction is to be found, in our judgment, in the fact that very often the worst cases of gastro-intestinal disorder yield more promptly to the brain remedies than to remedies affecting the gastric and intestinal membranes and glands. Yet it is not argued that the ptomaines cause the cerebral symptoms, rather that they are incident to and dependent upon the exhaustion following prolonged or severe acute gastro-intestinal involvement. Our experience goes to prove that the latter oftener follows the former than the former the latter. And especially is this so in very acute cases.

The topic is an interesting and practical one, and the experience of our California friends would seem to go to show climatic conditions are a very important factor in the etiology of summer complaints, while the experience of our New Orleans colleagues would go to show that while there may exist great climatic heat to cause milk and artificial food degeneration yet an out of door life affords practical immunity from fatality, which would hardly be the case were acute milk poisoning the cause of their cases of summer complaint. Put the testimony of California and New Orleans together, and add many individual experiences, like unto our own, and the bacteriological theory of summer complaints will need defending.

DISTRICT OF COLUMBIA MEDICAL BILL.

In its legislative department there will be found in this issue of this journal House Bill No. 7,661, being the bill prepared by the resident practitioners of the District of Columbia and presented to Congress by request by Mr. McMillen, of Tennessee, proposing the regulation of the practice of medicine in the District of Columbia. The bill is after the fashion of the regulation bill proposed by the American Medical Association, except that it proposes a joint board of examiners; not because the authors of the measure believe in joint boards, but because they know full well that they cannot secure the passage of a single board bill. But the bill is nevertheless very objectionable in many respects and we sincerely hope it will be defeated. It proposes, in the first place, a joint board with an Allopathic majority. The Washington Medical Society is to have five members, the Homeopathic Society three members and the Eclectic Society one member. This is not very bad for the old school, is hardly fair for us and decidedly unfair for the Eclectics. And, acting on the principle of fair play, our side should never be found acquiescing in the passage of a bill that does not give absolute fairness to all, even though the numbers of some school be small. In fact the smaller the relative numbers of practitioners in a given state, territory or district the greater the right of the minority to full representation. Once we accept the thought of "representation according to numbers," one of the most fallacious principles of government, when it comes to affairs of this character, whether we accept it for ourselves or become a party to its being foisted upon others, we immediately tie ourselves hopelessly tight in all mission fields and frontier districts and states. Homeopathy should never accept for herself minority representation on examining boards, nor should she become directly

or indirectly a party to an issue of this character when it presses other schools, as in this instance.

Another feature of the bill that is not fair nor in keeping with the policies of American legislalation is that it divides the profession in classes in giving exemption to all who are now practicing in the District while it places all new comers at the mercy of those exempted. This is class legislation of the worst sort and will in itself, according to the expressed opinions of many lawyers and judges, make it an unconstitutional measure. Legislation, as a rule, is intended to apply to things present as well as things future. If the people of Washington are suffering from quackery and ignorance on the part of their practitioners they are suffering now, and under this act will continue to suffer since those now on the field are to be allowed to continue their vocation. Hence the bill is faulty in this particular and should not be passed unless it be made to apply to all alike. No special privileges for the select few who may have gravitated, *nolens volens*, to Washington prior to the passage of this Act, if indeed it be passed.

Again. The bill proposes that all practitioners hereafter desiring to practice their profession in Washington shall submit to an examination in anatomy, physiology, chemistry, pathology, materia medica and therapeutics, hygiene, histology, practice of medicine, surgery, obstetrics and gynecology, diseases of the eye and ear, medical jurisprudence, and such other branches as may be deemed advisable. This character of examination is a bid for the student just out of college to the exclusion of the practitioner of years of experience. For what practitioner of, say, twenty or thirty or forty years of practice who might wish to locate in Washington and whose presence would be a valuable addition to the profession of the capital city could pass an examination in anatomy, chemistry and such special branches as medical jurisprudence and the eye and ear? It is sheer nonsense to ask it. Chemistry is today a profession distinct and separate from the practice of medicine. Ophthalmology requires all the time and ability and ingenuity of man, and the good oculist has neither time nor inclination for the general work of the profession. Likewise, it is folly for the general practitioner to try to keep up in ophthalmology. And histology, too! Who, in active work, attempts histology or special study in pathology? No one. Then what will be the result? The examination will be favorable to the student just out of college who is fresh in these minor and special departments and retarding to the pactitioner of experience, else it will be conducted in a farcical and haphazard way. In either sense it is wrong, and this sort of a bill should not be passed.

Further, the bill strikes right at the root of personal liberty in that it gives the board of examiners the right to revoke or refuse a license to practice medicine, the right of a qualified practitioner to earn a livelihood for himself and family, unless, forsooth, he follow the dictation of the board as to how he shall conduct his business. He shall not advertise his ability to cure the sick; no matter how expert he may become in special branches or lines of work, no matter how well qualified he may be to do all he claims he can do, no matter how badly people may need his services in these lines, and no matter how few of them may know of him and his ability in certain fields of professional labor, he shall not tell them of it in print else his head is to come off. Is this right? You or I may be a professor in a medical college. We may let this fact be known in a thousand ways. We may attend persons in high places, and thus the whole world may know of us. We may issue reprint after reprint of articles read at medical meetings or published in medical journals and it is all right. We may ride in our broughams, may drive spirited horses, may buy the best pew in the parish church, may attend the preacher for nothing, may court law suits for the notoriety they give, may engage in local politics, may go regularly to the theaters and be as regularly called out in a hurry to see some real or imaginary patient and it is all right. We are simply cute, smart, bright doctors, we! But the honest soul who hasn't the knavery to follow in our wake or who hasn't the wealth to pattern after us or who hasn't our pull on people in high places shall be asked by us to step down and out if he dares to advertise his business. Is this right? Is this American? Is this just? By no manner of means. It may not be in good taste to do these things. They may be thought not proper in regular professional circles, and medical societies may even proclaim against it and discipline members for doing thus. In proper place we will condemn and discountenance the advertiser as strongly as is just and right, but when it comes to making laws to regulate these matters we should make haste very slowly. There is already a great deal of "close corporationism" in the medical profession. The "holier than thou" people, while really few and far between, would have it appear that they are really much holier than thou and that thou must become holy too, even if thou hast to be forced by the closest kind of class legislation, by legislation against which we all would fight with vigor and persistency were it directed against us. Reasonable restriction in regard to the character of advertising that may be allowable may be all right in order to protect the people against false pretenders, but to broadly grant the privilege to any board of examiners to rescind a physician's right to earn a respectable and honest living for himself and family is not the kind of legislation the profession and people are calling for.

To our mind the District of Columbia needs no such law as the one proposed, and we sincerely hope it will be so amended as to have removed from it all these objectionable features. A registration law that requires practitioners to record a legitimately obtained diploma from a regularly chartered and legiti-

mately conducted medical college is all that is required, and all that should be asked of Congress. This talk about the District of Columbia being the dumping ground of other states is all nonsense. We have heard this cry from Massachusetts to Texas, from Florida to Oregon. It is a captious cry and has no merit. The profession of Washington is an unusually good one. Our side of it is not being overrun with quacks, nor do we believe the "regular" profession, as our old school friends like to call themselves, is swarming with them to any great extent. There may be a few Wm. A. Hammonds among them, and less earnest and energetic men may be pinched a little by their presence. But the people of Washington are not being murdered, they are not asking for protection, and this movement is like all such movements everywhere, very largely the outcome of selfishness and a thoughtless view of the situation. As a matter of fact we do not believe there is a reputable citizen in the Capitol City who is really suffering from the depredations of the class of people described in the caption of this bill, nor do we believe there exists the least real necessity for the enactment of such a measure. It is a bad precedent. If adopted at the capital this sort of bill will have unusual prestige over the country and will work much hardship upon Homeopathy where it is not strong, upon Eclecticism where it is not strong and upon the people who may not wish to die via either Allopathic, Homeopathic or Eclectic methods.

This bill will bear many amendments. It demands careful analysis, and while we do not like to array ourselves against any measure that is apparently directed toward the elevation of the profession or the advancement of its interests we cannot but look with the utmost of disfavor upon this measure and all like it, and, therefore, we hope it will be defeated out of sight if presented and pressed in its present form.

Editor's Table.

Dr. R. Kingsman of Washington, D. C., is taking a vacation at Asbury Park.

Our Dr. T. L. Macdonald will spend the month of September in the wilds of Pennsylvania.

Dr. J. B. Gregg Custis, Washington, is taking a much needed outing and rest in Canada.

Dr. Charles S. Evans, one of Chicago's Materia Medicists, is now located at 730 Warren avenue.

Dr. T. S. Verdi, Washington, has removed from Fourteenth street to 724 Seventeenth, near H street.

Dr. Wm. Woodburn has removed from Spencer to Des Moines, Iowa, with eye and ear offices in the Equitable building.

It is whispered in Chicago that the new post graduate school has purchased a site and will begin the erection of a college and hospital building in the near future.

Dr. Henry Sherry, Chicago, is off for San Antonio, where he contemplates spending a portion or all of the winter for his health.

Dr. T. S. Hoyne, of the *Medical Visitor*, who has been summering abroad, has returned and resumed his practice and journalistic duties.

Dr. Pratt's special course in orificial surgery will begin at the Chicago Homeopathic Medical College on Monday, September 3d, at 9 A. M.

Dr. Allison Clokey, Louisville, has adopted pedology as his specialty, and will hereafter devote his energies largely to the treatment of the little folk.

Those interested in orificial surgery must not forget that Dr. Pratt's special course on this subject begins at the Chicago Homeopathic Medical College on Monday, September 3.

Dr. C. A. Wilson, of San Antonio, Tex., has been rusticating and recuperating on Anderson's ranch, out in the mountainous district north of Kerrville, one of the most salubrious sanitariums in the great southwest.

The *Medical Visitor* for September contains the lists of Homeopathic physicians for the states of Minnesota, Mississippi, Missouri and Montana. As a rule the *Visitor's* lists are very satisfactory and accurate.

Dr. H. W. Westover, St. Joseph, Mo., is spending his vacation at Lake Miltona, Minnesota, catching all the fish in that beautiful pond. He reports it as a gem of beauty, with plenty of excellent fishing and boon companions.

Prof. E. M. Bruce will deliver the opening lecture at Hahnemann Medical College, in this city, on September 11. The formal opening of the new and commodious hopsital will immediately follow with proper ceremonies.

The nineteenth autumn and winter session of the Chicago Homeopathic Medical College, Chicago, will begin on Tuesday, September 18th, and continue six months. Prof. C. T. Hood, M. D., will deliver the introductory address.

Dr. Nelson O. Pennoyer, Kenosha, Wisconsin, mourns the loss of his father, whose death occurred at the Kenosha Sanitarium on the 29th of July. The sympathies of Dr. Pennoyer's many friends in the profession will go out to him freely in his affliction.

Dr. F. A. Gardner, Washington, the medical yachtsman of Nantucket, spent August and will spend this month in his yacht at that delightful watering place. It is said that he prefers his boat to his cottage, though he occasionally condescends to go ashore at meal time.

The next meeting of the Chicago Homeopathic Medical Society will be held at the Grand Pacific Hotel on Monday evening, September 3, at 8:30 o'clock sharp. A large attendance should be easily secured. Come everybody, and bring your neighbor. Visitors in the city are cordially welcome.

The next meeting of the Chicago Homeopathic Medical Society of Chicago, to be held Monday, September 3d, at 8:30 P. M., at the Grand Pacific Hotel will probably have a large attendance of physicians from outside the city owing to the attendance upon Dr. Pratt's special course. The local profession should, therefore, turn out in unusually good numbers. Let us have a full attendance.

Dr. W. H. Hanchett, Omaha, likes the MEDICAL CENTURY better and better, closing a pleasant compliment with the declaration that the editor hereof is doing broad and liberal work on the journal. Thank you, doctor. Better this than to be holding post mortems on medical association elections.

Dr. Macdonald writes us that the MEDICAL CENTURY'S suggestion of last winter has been accepted and acted upon and that the National Homeopathic Hospital has been thoroughly renovated and repainted inside and out. The National is doing good work for Homeopathy's sick and afflicted in the District of Columbia.

Dr. S. B. Parsons, of St. Louis, who has been summering at Kenosha, at Dr. Pennoyer's most excellent sanitarium, suffered a recurrence of hemorrhage of the lungs recently and for a time was quite ill, but is now recovering nicely, to the great satisfaction and delight of his many personal and professional friends.

From Dr. Macdonald it is learned that the so styled National Homeopathic College of Washington is a defunct affair. At least, he writes us, the building occupied by the institution last year has been renovated, repaired and thoroughly disinfected and is now being advertised for rent. There is no place in Homeopathy for bogus medical colleges.

The Board of Registration in Medicine and Surgery in Massachusetts has organized and entered upon its duties. The Homeopathic members of the board are Dr. D. E. Whittier, Fitchburg, for five years, and Dr. S. H. Blodgett, Cambridge, three years. The old school has three members and the Eclectics and Homeopathists each two members.

Miss Young, business manager of the MEDICAL CENTURY, has returned from her outing in Colorado and will take pleasure as before in issuing receipts for bills paid and enrolling names of new subscribers to the CENTURY. With the oncoming of fall it is expected that the business department of this and all other enterprising medical journals will take on a veritable boom.

In connection with the prospective typhoid fever number of this journal it may be well to suggest that we would like to have a few hundred, certainly a few score, of clinical hints in connection with this disorder for the MEDICAL CENTURY CLINIC. How do you treat typhoid? How do you feed typhoid patients? What is your rule or custom in regard to bathing, etc.? Tell us all about it, everybody.

The MEDICAL CENTURY credited a recent paper on Gynecological Reflexes to Dr. Wm. Lowe, Wentworth, South Dakota, when it should have been credited to Dr. George H. Fulford, Sioux Falls. The paper was sent us by Dr. Lowe, secretary of the South Dakota state society and bore no mention of its author. It was presumed to have been prepared and sent in by Dr. Lowe, hence the error, which is regretted.

If any of the MEDICAL CENTURY'S friends have a copy of the issue of this journal bearing date of January 1, 1894, that they can spare the courtesy will be most highly appreciated at this office. Our files for that issue, as for the issue of January 1, 1893, are exhausted. Look over your back numbers, friends, those of you who do not bind your journals, and if you find copies of these dates please send them to us and receive proper reward.

The Homeopathic Department of the University of Iowa has issued number three of the first volume of its Bulletin. It is full of valuable information concerning the department, and, among other things, contains an excellent illustration of the new Homeopathic medical college and hospital building. Under its present able management the Iowa school is prospering as never before, and it has finally got out of the rut of one-man-ism and its faculty is working in harmony, and successfully, for the good of the school.

Dr. T. F. Allen and son, Dr. Paul Allen, of New York, who have been conducting a post graduate school in Materia Medica, have consolidated their course with others in New York with the result that the Metropolitan Post Graduate School has been organized. Dr. Allen, Sr., is president of the board of trustees and Dr. A. R. McMichael is dean of the new school. Dr. Chas. Deady, of the Ophthalmological College is secretary of the new institution, in which it is proposed, we understand, to teach all branches of medical and surgical science. Further particulars in regard to this new organization will be awaited with impatience.

The reception of the announcement of the new Homeopathic Text Book of Surgery is something remarkable. Already several hundred advance subscriptions have been recorded and from many parts of the country come expressions of satisfaction because of its inception and preparation. Work on it is being pushed quite rapidly by several of the authors and it is expected the first pages will go to press within thirty days. It is the intention to have it ready for the market by the first of January next, and at this moment the prospects are excellent for the fulfillment of this intention. There shall be no unnecessary delay in its issuance.

Who can read Dr. T. L. Macdonald's most excellent and exhaustive article of Prostatic Hypertrophy, read before the surgical section of the American Institute at Denver, and Dr. J. M. Lee's splendid and practical article on Hernia, both of which appear in the current number of this journal, and fail to congratulate himself that he belongs to a school that has such able surgeons as these. We have had our Helmuth, Franklin, Schneider and Biggar. We now have also our Macdonald, Van Lennep, James, Lee, Green, Walton, Pratt, Wood, Shears, Adams, Chislett, Parsons, Morgan, McClelland, Ward, Miller, Gilchrist, Wilcox, New York and Buffalo, Bishop, Packard, Beebe, Boynton, and almost a score of others whose surgical present or future, or both, is as bright as could be desired. Homeopathy is growing in surgery, and growing rapidly indeed.

The programme for the next meeting of the Homeopathic Medical Society of Chicago contemplates a paper by Dr. J. P. Cobb, of Hahnemann Medical College, on the etiology, pathology and symptomatology of diarrheal diseases of infants, another by Dr. R. N. Tooker, of the Chicago Homeopathic Medical College, on the hygienic treatment of the same, a third by Dr. Wilson Smith, of the National Homeopathic College, on the medical treatment of these disorders, and a fourth by Dr. H. C. Allen, of Hering Medical College, on the differentiation of diarrheal remedies. This is a feast that we will all enjoy and there should be and doubtless will be a large attendance. The meeting will be held at the Grand Pacific Hotel on the evening of Monday, September 3, at 8.30. All resident members of the profession and visiting physicians are cordially invited to be present and participate in the meeting.